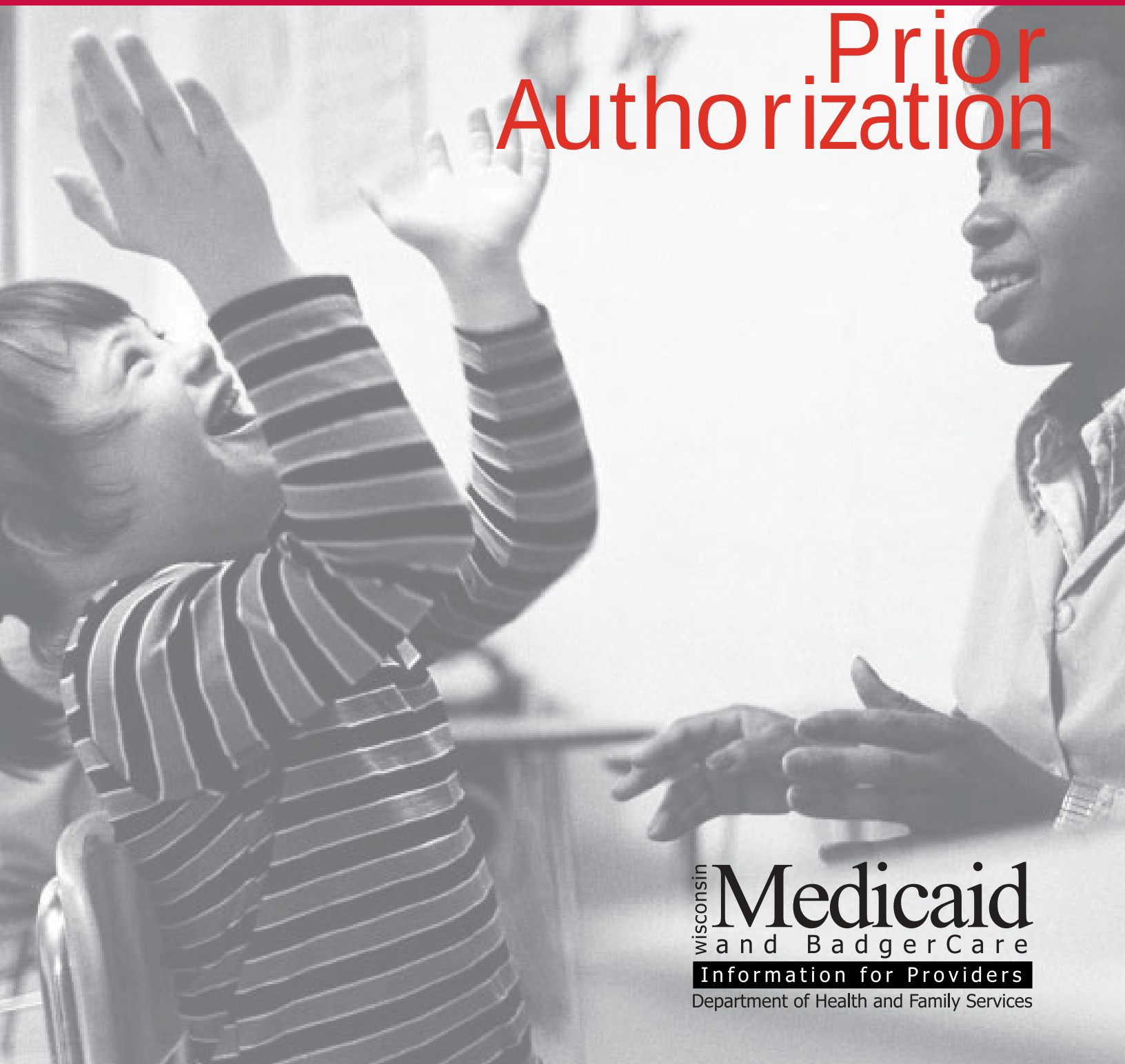
Speech and Language Pathology

Prior Authorization



wisconsin Medicaid and BadgerCare

Information for Providers

Department of Health and Family Services

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M E M O R A N D U M

DATE: May 1, 2003

TO: Rehabilitation Agencies, Speech and Language Pathologists, Speech and Hearing Clinics, Therapy Groups, Inpatient Hospital Providers, Outpatient Hospital Providers, Nursing Homes, and Managed Care Organizations

FROM: Peggy B. Handrich, Associate Administrator
Division of Health Care Financing

SUBJECT: Wisconsin Medicaid Speech and Language Pathology Handbook

The Division of Health Care Financing is pleased to provide you with a copy of the new Wisconsin Medicaid Speech and Language Pathology Handbook.

The Speech and Language Pathology Handbook incorporates all current Wisconsin Medicaid speech and language pathology information into a single reference source. This handbook replaces most prior speech and language pathology publications including Part O, Speech and Hearing Services Handbook (see below for a list of publications that this handbook replaces).

This handbook does **not** replace the All-Provider Handbook and all-provider *Updates,* the Wisconsin Administrative Code or Wisconsin Statutes. Subsequent changes to speech and language pathology policy will be published, first in *Wisconsin Medicaid and BadgerCare Updates*, and later in Speech and Language Pathology Handbook revisions.

Additional Copies of Publications
All *Updates* and the Speech and Language Pathology Handbook can be downloaded from the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/.*

We would like to thank everyone who reviewed this handbook.

Previous Medicaid Information
This handbook replaces the speech and language pathology information contained in the following *Updates*:

- MAPB-088-017-D.
- MAPB-090-021-D.
- 95-25: "Therapy recoding procedures."

- 97-14: “Birth to 3 Agencies may pay Medicaid insurance liability in certain situations.”
- October 1998: “Wisconsin Birth to 3 Program.”
- August 1999: “Birth to 3 and natural environments.”
- 2000-19: “Clarification of Birth to 3 and the Individualized Family Service Plan.”
- 2000-24: “Prior authorization of maintenance therapy.”
- 2000-55: “Medicaid requirements for speech-language pathology providers and non-billing performing providers.”
- 2000-60: “Prior authorization requests may now be faxed.”
- May 2001: “Clarification of prior authorization fax procedures.”
- 2001-37: “Introducing the revised PA/TA.”
- 2001-44: “Therapy providers eligible for natural environment enhanced reimbursement when providing services to children in the Birth to 3 Program.”

Important Telephone Numbers

Wisconsin Medicaid's Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility.

Service	Information Available	Telephone Number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:00 a.m. - 5:00 p.m. (M-F)

*Please use the information exactly as it appears on the recipient's identification card or the EVS to complete the patient information section on claims and other documentation.

Recipient eligibility information available through the EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

Table of Contents

Preface

The Wisconsin Medicaid and BadgerCare Speech and Language Pathology Handbook is issued to speech-language pathologists who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. As of January 2003, BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on the methods of verifying eligibility.

Handbook Organization

The Speech and Language Pathology Services Handbook consists of the following sections:

- General Information and Covered Services.
- Prior Authorization.
- Claims Submission.

In addition to the Speech and Language Pathology Services Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid and BadgerCare

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-498 — Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

www.dhfs.state.wi.us/medicaid/
www.dhfs.state.wi.us/badgercare/.

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

Prior Authorization Requirements

Providers need PA for certain specified services *before* they are provided.

According to HFS 107.02(3)(b), Wis. Admin. Code, prior authorization (PA) procedures are designed to:

- Safeguard against unnecessary or inappropriate care and services.
- Safeguard against excess payment.
- Assess the quality and timeliness of services.
- Determine if less expensive alternative care, services, or supplies are usable.
- Promote the most effective and appropriate use of available services and facilities.
- Curtail misutilization practices of providers and recipients.

As noted in HFS 107.18(2)(b), Wis. Admin. Code, PA is required for speech and language pathology (SLP) services after a recipient exceeds the allowed threshold of treatment days, as specified under "When Wisconsin Medicaid Requires Spell of Illness Approval" in this chapter, or under special circumstances.

Note: Prior authorization requirements outlined in this section do not apply to SLP services provided by home health agencies or inpatient hospitals. Refer to the Private Duty Nursing and Home Health Services Handbook or the Hospital Handbook for more information.

Providers need PA for certain specified services *before* they are provided. Wisconsin Medicaid does not reimburse providers for services provided either before the grant date or after the expiration date indicated on the approved Prior Authorization Request Form (PA/RF). If the provider delivers a service either before the grant date or after the expiration date of an approved PA, or provides a service that requires PA without obtaining PA, the *provider* is responsible for the cost of the service. Providers may not bill the recipient.

Prior authorization does not guarantee payment. Provider and recipient eligibility on the date of service, as well as all other Medicaid requirements, must be met in order for Wisconsin Medicaid to reimburse the claim.

Refer to the Prior Authorization section of the All-Provider Handbook for information on the following PA situations:

- Amending approved or modified PA requests.
- Appeal procedures.
- HealthCheck "Other Services."
- Prior authorization for out-of-state providers.
- Recipient loss of eligibility midway through treatment.
- Retroactive authorization.
- Circumstances under which a provider may charge a recipient for services that are not approved by Wisconsin Medicaid.
- Supporting materials.
- Transferring authorization.

Types of Authorization Requests

Therapy providers have three options for seeking authorization:

- Requesting PA by submitting a PA/RF with a Prior Authorization Therapy Attachment (PA/TA).
- Requesting spell of illness (SOI) approval by submitting a PA/RF with a Prior Authorization Spell of Illness Attachment (PA/SOIA).
- Requesting PA by submitting a PA/RF with a Prior Authorization Birth to 3 Therapy Attachment (PA/B3).

Refer to the Prior Authorization Submission chapter of this section for more information on the PA/RF, PA/TA, PA/B3, and PA/SOIA.

When Wisconsin Medicaid Requires Prior Authorization

Wisconsin Medicaid requires PA for SLP services under the following circumstances:

- Speech and language pathology services received in excess of the first 35 treatment days, regardless of the provider or the payment source, per HFS 107.18(2)(b) and 107.18(2)(g), Wis. Admin. Code.
- Starting with the first day of treatment for special circumstances, including:
  - √ Cotreatment (interdisciplinary treatment).
  - √ Unlisted (nonspecific) procedures, as noted in this handbook or subsequent *Wisconsin Medicaid and BadgerCare Updates*.
  - √ Procedures that always require initial PA, as noted in this handbook or subsequent *Updates* as requiring PA.
  - √ Certain conditions never qualify for an SOI, such as decubitus ulcers and mental retardation.

When Wisconsin Medicaid Requires Spell of Illness Approval

Providers are required to obtain approval from Wisconsin Medicaid for a new SOI, with the exception of the recipient's first SOI.* As specified in HFS 107.18(2) and 101.03(167), Wis. Admin. Code, an SOI begins with the first day of treatment or evaluation following the onset of a new disease, injury, medical condition, or increased severity of a pre-existing medical condition. In such cases, treatment is required because the recipient:

- Has incurred a demonstrated functional loss of ability to perform daily living skills and there is measurable evidence to support this.
- Has the potential to achieve his or her previous level of functional ability.

* A recipient's first SOI is the first time the recipient requires therapy in his or her lifetime. The recipient's first SOI in his or her lifetime does not need prior approval for payment of medically necessary services. After the first SOI, additional SOIs require approval for payment by submitting a PA/SOIA and the PA/RF. Submission of the PA/TA is required for SLP therapy services that exceed 35 treatment days.

Duration of a Spell of Illness

As stated in HFS 107.18(2)(d), Wis. Admin. Code, up to 35 treatment days are allowed per SOI. The 35 treatment days include all of the following:

- Evaluations.
- Treatment days covered by Medicare or health insurance.
- Treatment days provided by another provider in any setting.

Unused treatment days from one SOI cannot be carried over into a new SOI. When a new authorized SOI occurs within the current SOI, the old (current) SOI stops, and a new SOI begins. The new authorized SOI has 35 treatment days.

As noted in HFS 107.18(2)(d), Wis. Admin. Code, an SOI ends when the recipient's condition improves so that the services of a speech-language pathologist are no longer required or after 35 treatment days, whichever comes first.

Prior Authorization Versus Spell of Illness Approval

Speech and language pathology providers may always choose to request PA instead of SOI approval. For instance, a provider may request PA instead of SOI approval when treating an acute onset of a condition, such as a stroke. However, Wisconsin Medicaid will not approve an SOI request when PA is necessary.

As stated in HFS 107.18(2)(d), Wis. Admin. Code, up to 35 treatment days are allowed per SOI.

Refer to Appendix 1 of this section for a chart to help providers determine when a request for SOI approval is appropriate and when a request for PA is appropriate.

Providers are required to request PA (instead of SOI approval) when any of the following are true:

- The recipient has exceeded the 35 treatment days allowed per SOI.
- The recipient's condition is not acute or recent.
- The recipient's condition does not qualify for an SOI. (Certain conditions never qualify for an SOI, such as mental retardation or decubitus ulcers.)

Speech and language pathology providers are *encouraged* to request PA (rather than SOI approval) when:

- They are not sure if the recipient has received treatment from another provider for the current SOI.
- The recipient is expected to exceed the 35 treatment days allowed per SOI.

A request for SOI approval is only appropriate when both of the following are true, per HFS 107.18(2)(a), Wis. Admin. Code:

- The recipient has recently lost the ability to perform daily living skills, caused by a new disease, injury, medical condition, or by increased severity of a pre-existing medical condition.
- The recipient displays the potential to achieve the skill level that he or she had previously.

Refer to Appendix 1 of this section for a chart to help providers determine when a request for SOI approval is appropriate and when a request for PA is appropriate.

Prior Authorization for Birth to 3 Program

For children in the Birth to 3 (B-3) Program, Wisconsin Medicaid:

- Requires therapy providers to submit a PA request *only once* per child, per therapy type, per provider for therapy groups and for independent therapy providers.
- Requires rehabilitation agencies to submit a PA request *only once* per child per therapy type.
- Grants PA up to the recipient's third birthday.

Qualifying for the Prior Authorization for Birth to 3 Process

To qualify for submission of PA forms under this process, all services must be provided by Wisconsin Medicaid-certified therapists who are employed by, or under agreement with, a B-3 agency to provide B-3 services. To qualify for this process, the therapy services must be prescribed by a physician and be one or both of the following:

- Provided in conjunction with the B-3 initial evaluation and assessment in accordance with HFS 90, Wis. Admin. Code, even if the evaluation and assessment determines the child is not eligible for B-3 services.
- Identified in the recipient's Individualized Family Service Plan (IFSP) and performed at the same frequency, intensity, and duration listed in the IFSP. Wisconsin Medicaid will not reimburse beyond the frequency and duration specified in the prescription or the physician-signed plan of care.

Situations That Do Not Qualify for the Prior Authorization for Birth to 3 Process

Providers may not use the PA for B-3 process and PA/B3 for any of the following:

- Children who are not being evaluated as part of the initial B-3 assessment.
- Children who are not participating in the B-3 Program.
- Services provided by Wisconsin Medicaid therapists who are not employed by or under agreement with a B-3 agency to provide B-3 services.
- Services not identified in the IFSP.

- Procedure codes not listed in Appendix 2 of this section.
- Cotreatment services.

For situations that do not meet the criteria for the PA B-3 process, providers must follow Wisconsin Medicaid's current PA process. Refer to Appendix 2 of this section for a chart of *Current Procedural Terminology* (CPT) codes that may be performed when a B-3 PA is approved. Refer to Appendix 3 of this section for guidelines on choosing the correct PA form to submit. Refer to the rest of this section for more information on PA for services to children not eligible for the B-3 Program.

When to Submit Information for Prior Authorization for Birth to 3

Providers may use the PA/B3 in either of the following situations:

- Two to four weeks before the child's initial 35 treatment days per discipline per SOI have been used.
- At any time once a therapy evaluation or service has been initiated through the B-3 Program.

When Children Are Not Birth to 3 Program Participants

If a child is not in the B-3 Program, please refer to "Prior Authorization Forms Required for Speech and Language Pathology Services" of the Prior Authorization Submission chapter of this section for instructions on PA submission. *Providers are required to indicate on the PA/TA the reasons why the child is not a B-3 Program participant.*

Some children are not eligible for the B-3 Program. One example would be a child without developmental delays who needs therapy to recover from an accident or injury.

Providers are reminded that if they think a child will meet B-3 Program eligibility criteria, they are required to refer that child to the designated county B-3 Program within *two days of identification*, per HFS 90.07(3)(b), Wis. Admin. Code. Refer to the General Information and Covered Services section of this handbook for more information on the B-3 Program, including eligibility criteria and contact information.

Special Circumstances for Prior Authorization

Cotreatment (Interdisciplinary Treatment)

Cotreatment is only approved under specific and/or limited circumstances. Cotreatment allows for two therapists of different therapy disciplines to simultaneously treat a recipient and submit a claim for the same time period. For example, if a recipient is treated by an occupational therapist and a speech-language pathologist from 1:00 to 2:00, both therapists could submit a claim to Wisconsin Medicaid for one hour.

Cotreatment is only approved under specific and/or limited circumstances.

All cotreatment requires PA. Prior authorization requests for cotreatment must document both of the following:

- That individual treatment from one therapist does not provide maximum benefit to the recipient.
- That two different therapies *simultaneously* treating the recipient are required.

Each of the providers (e.g., occupational therapist and physical therapist or occupational therapist and speech-language pathologist) involved in cotreatment must complete a separate PA/RF and submit the requests to be processed *at the same time*. Providers may either mail the requests in the same envelope or fax the requests at the same time.

In addition to completing the required elements on the PA/RF, each provider is required to include the following:

- A specific request for cotreatment.
- Documentation of the medical necessity for cotreatment.
- Identification of the other cotreatment provider type.

Multiple Speech-Language Pathologists

If two or more speech-language pathologists from different community agencies or organizations request dual treatment for one recipient, each provider must complete a separate PA/RF and submit the various requests to be processed *at the same time.* Providers may either mail the requests in the same envelope or fax the requests at the same time.

In addition to completing the required elements on the PA/RF, each provider is required to include the following information:

- A specific request for dual treatment.
- Documentation of the medical necessity for dual treatment.
- Specific days of the week each provider administers the service.
- Procedures for the coordination of the treatment plans.
- The specific and unique contribution of each therapist.

If two or more speech-language pathologists from different community agencies or organizations request dual treatment for one recipient, each provider must complete a separate PA/RF and submit the various requests to be processed *at the same time.*

Maintenance Therapy Services

Wisconsin Medicaid will only consider a PA request for maintenance therapy services when one or more of the following conditions are met:

- The skills and training of a therapist are required to execute the entire preventive and maintenance program.
- The specialized knowledge and judgement of a speech-language pathologist are required to establish and monitor the therapy program.
- When, due to the severity or complexity of the recipient's condition, nursing personnel cannot handle the recipient safely and effectively.

Approving Maintenance Therapy Services

PA requests for maintenance therapy services may be approved when the therapist documents both of the following:

- That the recipient's functional abilities would not be maintained without therapy.
- That the skills of a therapist are required to maintain a skill level.

When evaluating a PA request, special consideration is given to the following:

- Where the recipient lives (e.g., nursing home, group home, private residence).
- Caregivers involved with the recipient.
- The exercises that have been prescribed in the home exercise program/preventive maintenance plan (HEP/PMP).
- The specific functional outcomes of the HEP/PMP.
- Who assists the recipient with the HEP/PMP.
- What skills and expertise the therapist brings to the maintenance plan.
- The outcome of intervention.

This information, in combination with the recipient's diagnosis, history, present level of function, cognitive abilities, and the chronic/progressive nature of the diagnosis/current condition, etc., is evaluated to determine whether or not the PA request for maintenance therapy is approved. Each of these elements should be clearly documented in the PA request.

Execution of the Program

Prior authorization for maintenance services may be requested and approved for any frequency. In general, when maintenance services are approved at a frequency of two times per week, the therapist's skills and

expertise are needed to provide a "hands-on" treatment that allows the recipient to maintain his or her functional abilities.

Typically, in "hands-on" treatment:

- The plan of care and the recipient's condition require a constant adjustment of therapeutic input and/or constant use of therapeutic principles.
- The two-times-per-week treatment intervention allows the recipient a specific level of functional independence.

It is generally not considered effective maintenance of the recipient's functional level when "hands-on" treatment is provided one time per week or less. For maintenance to be effective, the recipient should be involved in a routine HEP/PMP.

Routine HEP/PMPs can be performed by another caregiver or the recipient. Daily, twice daily, or "as necessary" HEP/PMPs will influence the recipient's functional abilities at the most opportune time and are considered more effective than a treatment session provided one time per week or less.

Monitoring and Modifying the Program

Prior authorization requests to monitor and modify a maintenance therapy program that caregivers typically carry out may be approved.

Modifications of home programs require the specific skills and knowledge of a speech-language pathologist. It is expected that the recipient's medical condition or functional abilities change often enough to warrant evaluation and modification of the HEP/PMP at the frequency requested.

Approved maintenance therapy services may also involve the process of teaching a routine HEP/PMP to a caregiver to assure follow-through and understanding of the HEP/PMP techniques. The requested frequency should reflect the need for intervention/teaching from a therapist.

The frequency the provider chooses to request when the goal is to modify an HEP/PMP should be based upon the predictability of change. Subsequently, an assessment to modify an HEP/PMP needs to be justified in a PA by a change in the recipient's medical condition, living situation (including equipment), functional requirements, caregiver status, and/or specific changes to the HEP/PMP.

For maintenance to be effective, the recipient should be involved in a routine HEP/PMP.

Intervention in the Maintenance Therapy Program

Occasionally a therapist will evaluate and treat a recipient for a certain amount of time, instruct the caregivers in an HEP/PMP, and then discontinue the recipient from active therapy intervention.

When there is an established treatment program and the recipient's response to treatment *is predictable*, the following examples of HEP/PMP focus areas, which after initial treatment and instruction may not require the skills and expertise of a speech-language pathologist, will not be covered by Wisconsin Medicaid:

- Fluency (e.g., stuttering).
- Voice quality.
- Expressive language.
- Language structure, content, and/or functions.

The recipient's maintenance program may require the skilled intervention of a speech-language pathologist if there is documentation that the nursing staff/caregivers had routinely performed the HEP/PMP as prescribed, but the outcome was affected by one or more of the following:

- The recipient had or continues to have complicating factors related to his or her diagnosis.
- There were unforeseeable problems associated with the recipient's functional abilities being maintained by other caregivers.

- The speech-language pathologist reassessed the HEP/PMP, and the recipient's health continued to be at risk.

In these situations it may be necessary for a speech-language pathologist to provide a period of brief, intensive treatment (if the recipient's status had regressed) prior to resumption of a maintenance program. The situations may require a new PA.

In these situations it may be necessary for a speech-language pathologist to provide a period of brief, intensive treatment (if the recipient's status had regressed) prior to resumption of a maintenance program.

Extension of Therapy Services

As specified in HFS 107.18(3)(e), Wis. Admin. Code, a PA request to extend therapy services (i.e., continuation of therapy services) is not approved in the following circumstances:

- The recipient shows no progress toward meeting or maintaining established and measurable treatment goals over a six-month period, or the recipient shows no ability within six months to carry over abilities gained from treatment.
- The recipient's chronological or developmental age, lifestyle, or home situation indicates the stated goals are not appropriate for the recipient or serve no functional or maintenance purposes.
- The recipient has achieved independence in daily activities or can be supervised and assisted by restorative nursing personnel, active treatment staff, activity or recreation staff, caregivers, or family.
- The evaluation indicates the recipient's abilities are functional for the recipient's present lifestyle.
- The recipient shows no motivation, interest, or desire to participate in therapy.
- Other therapies or treatment are providing sufficient services to meet the recipient's functional needs.
- The services are any of the following:
  - √ Not medically necessary under HFS 101.03(96m), Wis. Admin. Code. (Refer to the Glossary of Common Terms of this section for the definition.)
  - √ Experimental under HFS 107.035, Wis. Admin. Code. (Refer to the Glossary of Common Terms of this section for the definition.)
  - √ Not covered under HFS 107.03, Wis. Admin. Code. (Refer to the Covered and Noncovered Services section of the All-Provider Handbook for more information.)
  - √ Not reimbursable under HFS 107.02(2), Wis. Admin. Code. (Refer to the Covered and Noncovered Services section of the All-Provider Handbook for more information.)

Prior Authorization Submission

Wisconsin Medicaid requires providers to submit each *new* request for PA on a *new* PA/RF so that the request is processed under a *new* number.

To expedite the prior authorization (PA) process, it is essential that providers follow the instructions found in this chapter and the Prior Authorization section of the All-Provider Handbook.

Contact Wisconsin Medicaid's Provider Services at (800) 947-9627 or (608) 221-9883 with PA questions that are not answered in this section or in the Prior Authorization section of the All-Provider Handbook.

Prior Authorization Forms Required for Speech and Language Pathology Services

Providers are required to submit a Prior Authorization Request Form (PA/RF) when requesting PA, spell of illness (SOI) approval, or initial PA for Birth to 3 (B-3) services for speech and language pathology (SLP) services.

Each PA/RF has a unique seven-digit, preprinted number in the upper center of the form. This number is the PA number that must be used on a claim because it identifies the service on the claim as a service that has been authorized.

Wisconsin Medicaid requires providers to submit each *new* request for PA on a *new* PA/RF so that the request is processed under a *new* number. *Since the PA/RF number is used to identify a single PA request, do not photocopy this form for other requests*. Refer to Appendix 4 of this section for PA/RF completion instructions. A completed sample PA/RF is included in Appendix 5 of this section.

Prior Authorization Codes

Refer to Appendix 17 for a list of SLP procedure codes. For the most current list of SLP procedure codes and their respective fees, visit *www.dhfs.state.wi.us/medicaid/* and do the following:

- Click on "Providers."
- Under References/Tools, click on "Fee Schedules."
- Click on "Therapy."

Prior Authorization Therapy Attachments

Submit the following forms when requesting PA:

- A correctly completed PA/RF.
- A correctly completed Prior Authorization Therapy Attachment (PA/TA).

A different attachment is required to request services for children participating in the B-3 Program. Refer to "Birth to 3 Attachments" in this chapter for more information.

Refer to the following appendices of this section for a completed sample PA/TA and instructions:

- Appendix 6 for PA/TA completion instructions.
- Appendix 7 for a sample PA/TA form.
- Appendix 8 for a blank PA/TA that may be photocopied.

Spell of Illness Attachments

Submit the following forms when requesting SOI approval:

- A correctly completed PA/RF.
- A correctly completed Prior Authorization Spell of Illness Attachment (PA/SOIA).

Refer to the following appendices of this section for completed sample SOI request forms and instructions:

- Appendix 9 for PA/RF completion instructions for SOI approval.
- Appendix 10 for a sample PA/RF for SOI approval.
- Appendix 11 for PA/SOIA completion instructions.
- Appendix 12 for a sample PA/SOIA.
- Appendix 13 for a blank PA/SOIA that may be photocopied.

Birth to 3 Attachments

Submit the following forms when requesting PA for B-3 Program services:

- A correctly completed PA/RF.
- A correctly completed Prior Authorization Birth to 3 Therapy Attachment (PA/B3).

Refer to the following appendices of this section for a completed sample PA/B3 and instructions:

- Appendix 14 for PA/RF instructions for B-3 approval.
- Appendix 15 for a sample PA/RF for B-3 approval.
- Appendix 16 for a blank PA/B3 for photocopying.

Obtaining Prior Authorization Forms

Providers may obtain PA/RFs, PA/TAs, PA/B3s, and PA/SOIAs by writing to:

Wisconsin Medicaid
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

Providers may also obtain PA/TAs, PA/SOIAs, and PA/B3s by photocopying the blank forms in Appendices 8, 13, and 16, respectively, of this section.

Documenting Medical Necessity on Prior Authorization Requests

Please note that the following information does not apply to B-3 Program services. Refer to "Prior Authorization for Birth to 3 Program" in the Prior Authorization Requirements chapter of this section for more information.

Providers are required to include documentation that justifies the medical necessity of the requested procedure when requesting PA or SOI. If the required documentation is missing from the request form, Wisconsin Medicaid will return the request to the provider.

Refer to Appendix 18 for more information on how medical necessity is determined.

Submit the following as applicable with the PA/RF:

- A completed PA/TA or PA/SOIA.
- A full and complete written report of the evaluation results and recommendations. The provider is required to submit the evaluation results with the PA/RF within two weeks of conducting an initial evaluation.
- Documented pertinent medical/social history that describes how/when/why and by whom it was determined that the recipient's functional abilities may be improved with therapy intervention.
- Documented frequency and duration; this information should be the same on both the PA/RF and the PA/TA and should be consistent with the illness, injury or disability, goals, and prognosis.
- Description of medical and treatment diagnoses.
- A plan of care relating to evaluation results and progress, and prognosis considering illness, injury, and/or diagnosis and requires skilled therapy services.

Providers are required to include documentation that justifies the medical necessity of the requested procedure when requesting PA or SOI.

The IFSP does not establish medical necessity.

- Rehabilitation potential statement that is consistent with illness, injury, and/or disability, and plan of care frequency/ duration requested.
- Required attachments.
- Instructions for follow-through or carryover by the recipient and/or caregiver. Carryover or follow-through is to be realistically achievable by the recipient and/or caregiver both at the place of residence and other community settings in which the recipient participates (e.g., in a sheltered workshop). If carryover is not possible within six months of initiating treatment, continued authorization may not be approved under HFS 107.18(3)(e)1, Wis. Admin. Code.
- Progress statements. The progress statements should include, in specific, objective, and measurable terms, information relating to progress in oral, motor, speech, language, voice, cognition, and swallowing in areas of performance of independent living/functional skills.
- A copy of the Individualized Family Service Plan (IFSP) if therapy is being requested for a B-3 Program participant through the PA/TA and not the B-3 PA process. Refer to "Prior Authorization for Birth to 3 Program" in the Prior Authorization Requirements chapter of this section and "Individualized Family Service Plans" in this chapter for information on submitting PA/TA for B-3 participants and when to use the PA B-3 process.*
- The Individualized Education Plan (IEP) if therapy is being requested for a school-age child.*
- A copy of the Interdisciplinary Program Plan (IPP) if therapy is being requested for a recipient in a residential or day facility for the developmentally disabled.* The IPP must document coordination and integration of the active treatment and medical care plan of the recipient.

*Only one team member needs to submit the IFSP, IEP, or IPP with his or her PA request. Therefore, the team should discuss who will attach the IFSP, IEP, or IPP to his or her PA request, and the other therapists should reference this PA number and the date the PA was submitted. The team member designated to submit the IFSP, IEP, or IPP should receive an additional copy from the coordinator. If the recipient does not have an IFSP, IEP, or IPP, the provider is required to indicate on the PA/TA why these documents do not exist.

Individualized Family Service Plans

Providers only need to include the following components of the IFSP when they must submit a PA/TA for B-3 services instead of using the PA/B3 (refer to "Prior Authorization for Birth to 3 Program" in the Prior Authorization Requirements chapter of this section for more information on the PA/B3):

- The child's health history and current medical status, including hearing and vision screening.
- A summary of the child's development in the following five areas:
  - √ Cognition.
  - √ Physical development (fine and gross motor skills).
  - √ Communication development.
  - √ Social/emotional development.
  - √ Adaptive development (including self-help skills).
- Concerns, priorities, and resources as identified by the family and other team members.
- Functional outcomes, including the strategies (this will include the follow-through plans for the child's family) and evaluation criteria.
- Summary of services.

In accordance with HFS 90, Wis. Admin. Code, the IFSP describes the outcomes, strategies, supports, and services appropriate to meet the child's and family's needs. The IFSP does not establish medical necessity.

Submission of the Individualized Family Service Plan

After the IFSP has been submitted once, only the sections of the IFSP that change significantly will need to be submitted to Wisconsin Medicaid. This will typically be:

- The annual update on developmental status.
- Changes in outcome that may be developed at either six-month or annual reviews.

Submission of Prior Authorization Forms

Providers have two choices for submitting completed PA requests:

- By mail.
- By fax.

Prior authorization requests received after 1 p.m. are processed on the following business day. Prior authorization requests received on Saturday, Sunday, or legal holidays are processed on the next business day.

Wisconsin Medicaid makes decisions on PA requests within the time frames outlined in the Prior Authorization section of the All-Provider Handbook, regardless of whether the requests are mailed or faxed.

Note: Providers are required to submit PA requests containing X-rays, video tapes, or photos by mail.

Submission by Mail

Providers may mail completed PA/RFs, PA/TAs, PA/SOIAs, and PA/B3s to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

For reference or further correspondence, providers are encouraged to photocopy their paperwork before sending it in.

Submission by Fax

Providers may fax PA requests to Wisconsin Medicaid at (608) 221-8616.

When faxing PA requests, providers are required to submit all forms and documentation together; they *should not* fax the forms and then mail the supporting documentation separately.

When faxing PA requests, providers are required to submit all forms and documentation together; they *should not* fax the forms and then mail the supporting documentation separately.

Refer to Appendix 19 of this section for more procedures on faxing PA requests.

Response Back from Wisconsin Medicaid

Once Wisconsin Medicaid reviews a PA request, Wisconsin Medicaid will fax one of three responses back to the provider:

- "Your request(s) has been adjudicated. See attached PA request(s) for the final decision."
- "Your request(s) requires additional information. See attached PA request(s). Fax the requested information with the same PA form immediately to expedite the finalization of your request."
- "We are unable to read your faxed PA request. Please resubmit the same request."

When additional information is requested, providers are required to resubmit the faxed copy of the entire original PA request, including attachments, with the additional information requested. If any attachments or additional information are received without the rest of the PA request, the information will be returned to the provider.

For both faxed and mailed requests, Wisconsin Medicaid will mail the decision back to the provider if:

- The provider does not include his or her fax number on the transmittal form.
- The fax is not successfully transmitted after three attempts.

Responses to Prior Authorization Requests

Every PA request stands on its own merit, documenting the need for therapy services and describing the recipient's unique circumstances at the time the PA request is submitted.

Providers may inquire about the status of a request by accessing the Automated Voice Response (AVR) system or by contacting Provider Services at (800) 947-9627 or (608) 221-9883. In order to use the AVR system effectively, providers should have the prior authorization (PA) number and the recipient's Wisconsin Medicaid identification number ready when they call.

Wisconsin Medicaid recognizes that a recipient's abilities, needs, and medical conditions are unique and have the potential to change. Therefore, approval on one PA does not guarantee approval on all PAs.

Conversely, a denied PA should not be interpreted to mean that therapy services will not meet the definition of medical necessity in the future. Every PA request stands on its own merit, documenting the need for therapy services and describing the recipient's unique circumstances at the time the PA request is submitted.

Refer to the Prior Authorization section of the All-Provider Handbook for more information on Wisconsin Medicaid responses to PA requests.

Review of Prior Authorization Decisions

After review by Wisconsin Medicaid consultants, the PA request is:

- Approved.
- Approved with modification.
- Denied.
- Returned to the provider for additional clinical information or clarification.

Refer to the Prior Authorization section of the All-Provider Handbook for more information on each of these responses.

Only recipients can appeal modified or denied PA requests. When a request is modified or denied, the recipient receives a "Notice of Appeal Rights" letter. Refer to the Prior Authorization section of the All-Provider Handbook for a copy of this letter and for information on how a provider and a recipient may respond to Wisconsin Medicaid's review of a PA request.

Amending Approved Prior Authorization Requests

When medically necessary, providers may request amendment of approved or modified PA requests to change:

- The frequency of treatment.
- The specific treatment codes.
- The grant or expiration dates.
- The request for cotreatment.

Prior authorization expiration dates may be amended up to one month beyond the original expiration date if the additional services are medically necessary and therapy will be discontinued after a brief extension of the therapy services.

For example, Wisconsin Medicaid may approve an amendment request for a brief (less than one month) extension of the original time period approved on the Prior Authorization Request Form (PA/RF) when the recipient's medical condition is reasonably anticipated to improve during the extension period. The recipient's condition must be expected to improve enough that therapy services will no longer be medically necessary following the requested extension.

Wisconsin Medicaid recommends that providers submit a new PA request if the therapy will continue for longer than one month beyond the expiration date.

The request to amend the PA/RF should include:

- A copy of the original PA/RF.
- The specific, requested changes to the PA/RF.
- A document explaining or justifying the requested changes. This may include a new evaluation, plan of care, goals, etc.
- A corresponding physician's prescription, if necessary.

The request to amend a PA/RF may be mailed to the PA Unit at:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers may also fax requests to amend a PA/RF to (608) 221-8616.

Amendment Request Approval Criteria

Wisconsin Medicaid may approve an amendment request if the request is:

- Medically necessary under HFS 101.03(96m), Wis. Admin. Code.
- Submitted before the date of the requested change.
- Fully explained and documented. Clinical documentation of the medical necessity justifying the request is required.

Note: At the end of a possible extension period, providers are required to submit a new request for PA instead of requesting an extension if one of the following occurs:

- The recipient's medical condition changes significantly, requiring a new plan of care.
- Similar services are expected to be medically necessary.

Reasons Prior Authorization Amendment Requests Are Denied

Wisconsin Medicaid may deny PA amendment requests for such reasons as:

- The requests are not medically necessary.
- The requests are solely for the convenience of the recipient, the recipient's family, or the provider.
- The requests are not received before the date of the requested change.
- The PA expired prior to receipt of the amendment request.
- The recipient's medical condition changes significantly, requiring a new plan of care.
- The requests are to allow for a vacation, missed appointments, illness, or a leave of absence by either the recipient or the provider.

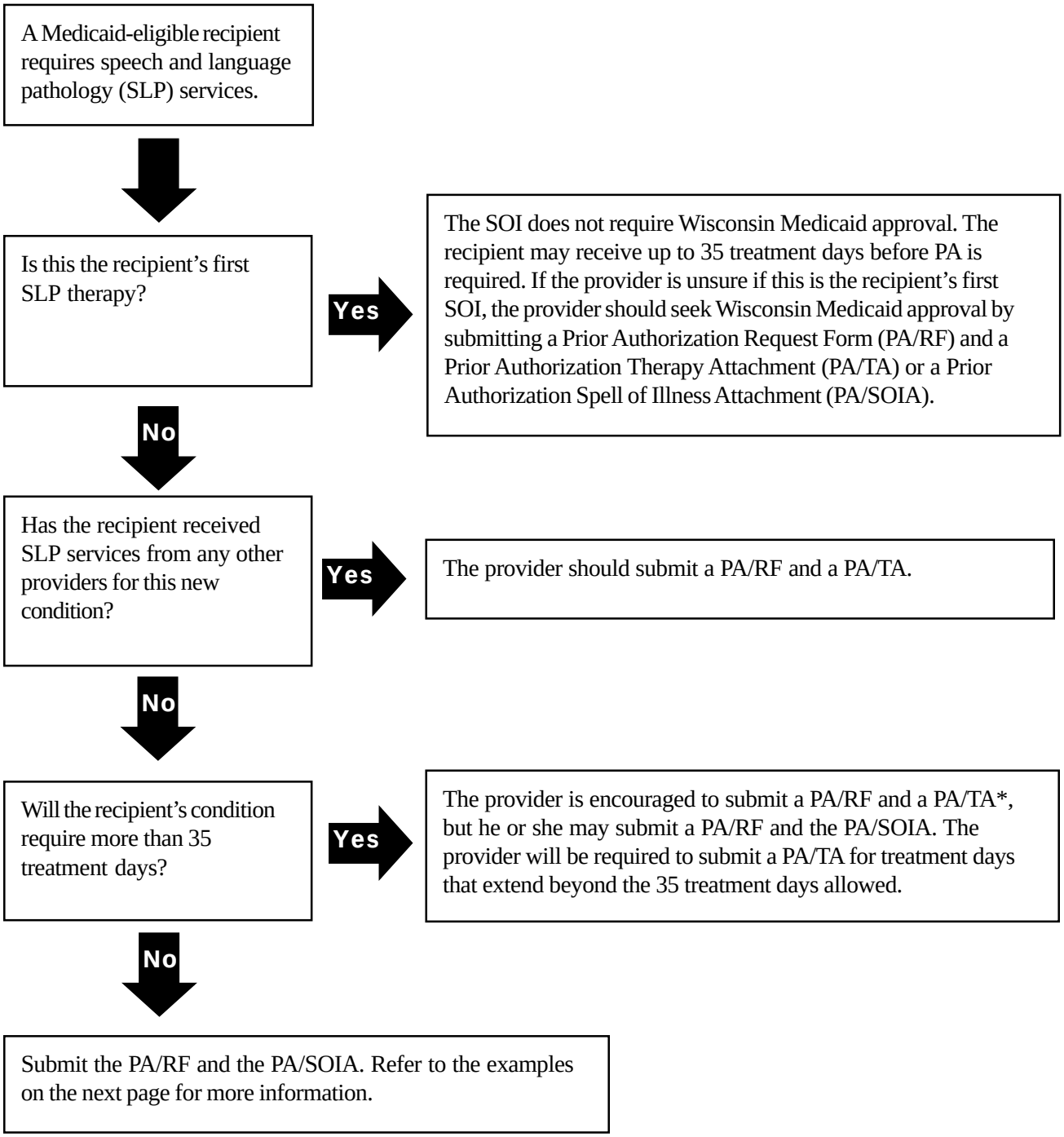
Wisconsin Medicaid may approve an amendment request if the request is fully explained and documented.

Appendix

Appendix 1

Prior Authorization Versus Spell of Illness Guide

Use the following flow chart to determine whether a request for prior authorization (PA) or spell of illness (SOI) approval is appropriate.



*Requesting PA is *always* an option for providers. Wisconsin Medicaid will not deny a PA request that meets the necessary approval criteria when an SOI approval request would have been appropriate. However, Wisconsin Medicaid will deny an SOI approval request when PA is necessary.

Determining When Spell of Illness Approval is Appropriate

The following charts illustrate two examples in which the provider must determine if he or she should seek PA or SOI approval for a recipient's condition.

Example 1: The recipient's condition **does** qualify for Wisconsin Medicaid SOI approval.

A Medicaid-eligible recipient with multiple sclerosis experiences a regression in his condition. Intensive SLP intervention will allow the recipient to achieve the skill level that he had previously, qualifying him for an SOI. The recipient does not have commercial health insurance.

The provider does not anticipate the recipient's treatment will require more than 35 treatment days. The provider seeks SOI approval by submitting the PA/SOIA because:

- The recipient is not expected to exceed the 35 treatment days allotted for that SOI.
- The recipient's condition is recent.
- The recipient demonstrates the ability to achieve the skill level he had previous to the regression of his condition.

If the recipient's treatment exceeds the 35 treatment days, the provider is required to seek PA from Wisconsin Medicaid by submitting the PA/TA.

Note: In the above situation, the provider also has the option of seeking PA by submitting the PA/TA.

Example 2: The recipient's condition **does not** qualify for Wisconsin Medicaid SOI approval.

A Medicaid-eligible recipient has a stroke. The recipient displays the ability to achieve the skill level that she had previously, qualifying her for an SOI.

The recipient has already received 35 treatment days in an outpatient hospital.

The speech-language pathologist should request PA from Wisconsin Medicaid, and not an SOI approval, because:

- The recipient has exceeded the 35 treatment days for that SOI.
- The recipient's condition is no longer recent.

Wisconsin Medicaid will not approve a PA/SOIA request. The provider should seek PA instead.

Appendix 2

Birth to 3 CPT Codes

The following chart lists *Current Procedural Terminology* (CPT) codes that may be performed when a prior authorization (PA) for Birth to 3 (B-3) services is approved. Providers requesting PA for codes that are not included below are required to request PA using Wisconsin Medicaid's current policies and procedures. Providers may use any of these codes, as appropriate, for the Individualized Family Service Plan (IFSP). Wisconsin Medicaid does not reimburse beyond the frequency, intensity, and duration of services listed in the IFSP, prescription, or physician-signed plan of care, whichever indicates the least amount of services.

Speech and Language Pathology CPT Codes and Descriptions	
92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual
92508*	group, two or more individuals
92526	Treatment of swallowing dysfunction and/or oral function for feeding
G0195	Clinical evaluation of swallowing function (not involving interpretation of dynamic radiological studies or endoscopic study of swallowing)
G0197	Evaluation of patient for prescription of speech generating devices
G0198	Patient adaptation and training for use of speech generating devices
G0199	Re-evaluation of patient using speech generating devices
G0200	Evaluation of patient for prescription of voice prosthetic
G0201	Modification or training in use of voice prosthetic

Note: In accordance with Medicare, providers cannot submit claims for services performed for less than eight minutes.

* Wisconsin Medicaid limits group to two to four individuals.

Appendix 3

Prior Authorization Situational Table

The chart below is a breakdown of when providers should submit the Prior Authorization/Birth to 3 Therapy Attachment (PA/B3), the Prior Authorization Spell of Illness Attachment (PA/SOIA), or the Prior Authorization/Therapy Attachment (PA/TA).

Providers are reminded that they are always required to submit a Prior Authorization Request Form (PA/RF), regardless of the attachments they send.

Situation	Therapy Services Are Provided as Part of the Birth to 3 (B-3) Program by B-3 Agency-Contracted Providers Which Form?	Therapy Services Are Provided Outside the B-3 Program Which Form?
Initial B-3 eligibility evaluation/assessment.	Submit the PA/B3.	N/A.
Services in excess of 35 treatment days per spell of illness.	Submit the PA/B3.	Submit the PA/SOIA or the PA/TA.
Services provided during the development of a permanent or interim Individualized Family Service Plan (IFSP).	Submit the PA/B3.	Submit the PA/SOIA or the PA/TA.
Services (other than the initial evaluation) not included in the IFSP. (For example, if the child receives speech and language pathology [SLP] services from a non-B-3 SLP provider.)	N/A.	Submit the PA/SOIA or the PA/TA.
Services exceed the frequency established in the IFSP. (Frequency must be specific; ranges of time are not accepted. For example, "2 to 3 times per week" is not acceptable.)	N/A.	Submit the PA/SOIA or the PA/TA.
Services provided on or after the child's third birthday.	N/A.	Submit the PA/SOIA or the PA/TA.
Unlisted (nonspecific) procedure codes.	Submit the PA/SOIA or the PA/TA.	Submit the PA/SOIA or the PA/TA.
Cotreatment.	Submit the PA/SOIA or the PA/TA.	Submit the PA/SOIA or the PA/TA.

Appendix 4

Prior Authorization Request Form (PA/RF) Completion Instructions (Speech and Language Pathology)

Note: Refer to Appendix 7 of this section for Prior Authorization Request Form (PA/RF) for spell of illness completion instructions.

Element 1 — Processing Type

Enter processing type 113 — Speech and language pathology therapy. The "processing type" is the three-digit code used to identify a category of service requested.

Element 2 — Recipient's Medical Assistance ID Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 3 — Recipient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 4 — Recipient Address

Enter the complete address (street, city, state, and ZIP code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 — Date of Birth

Enter the recipient's date of birth in MM/DD/YYYY format (e.g., June 30, 1975, would be 06/30/1975).

Element 6 — Sex

Enter an "X" to specify whether the recipient is male or female.

Element 7 — Billing Provider Name, Address, ZIP Code

Enter the billing provider's name and complete address (street, city, state, and ZIP code). *No other information should be entered into this element since it also serves as a return mailing label.*

Element 8 — Billing Provider Telephone Number

Enter the billing provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 — Billing Provider No.

Enter the billing provider's eight-digit Medicaid provider number.

Element 10 — Dx: Primary

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested for the recipient.

Element 11 — Dx: Secondary

Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

Element 12 — Start Date of SOI (not required)

Element 13 — First Date Rx (not required)

Element 14 — Procedure Code

Enter the appropriate Wisconsin Medicaid-assigned five-digit procedure code for each service/procedure/item requested.

Element 15 — MOD (not required)

Element 16 — POS

Enter the appropriate Medicaid single-digit place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Code	Description
0	Other
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
4	Home
7	Nursing Facility
8	Skilled Nursing Facility

Element 17 — TOS

Enter the appropriate Medicaid single-digit type of service code for each service/procedure/item requested.

Code	Description
1	Medical
9	Rehabilitation Agency

Element 18 — Description of Service

Enter a written description corresponding to the appropriate five-digit procedure code for each service/procedure/item requested.

Element 19 — QR

Enter the quantity requested for each service/procedure/item requested.

Element 20 — Charges

Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the PA/RF should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to the Department of Health and Family Services' *Terms of Reimbursement*.

Element 21 — Total Charge

Enter the anticipated total charge for this request.

Element 22 — Billing Claim Payment Clarification Statement

An approved authorization does not guarantee payment. Reimbursement is contingent upon the recipient's and provider's eligibility at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is in accordance with Medicaid methodology and policy. If the recipient is enrolled in a managed care program at the time a prior authorized service is provided, Wisconsin Medicaid reimbursement is only allowed if the service is not covered by the managed care program.

Element 23 — Date

Enter the month, day, and year (in MM/DD/YYYY format) the PA/RF was completed and signed.

Element 24 — Requesting Provider Signature

The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element. Providers may enter the requested start date after the requesting provider's signature.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER — THIS SPACE IS USED BY THE WISCONSIN MEDICAID CONSULTANT(S) AND ANALYST(S).

Appendix 5

Sample Prior Authorization Request Form (PA/RF) (Speech and Language Pathology)

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 0750456

1 PROCESSING TYPE: 113

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima
4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow St. Anytown, WI 55555
5 DATE OF BIRTH: MM/DD/YYYY
6 SEX: M ☐ F ☒
8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I.M. Billing, 1 W. Williams, Anytown, WI 55555
9 BILLING PROVIDER NO.: 87654300
10 DX: PRIMARY: 315.31 Language delays
11 DX: SECONDARY: 783.4 Developmental delays
12 START DATE OF SOI:
13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
92506		3	1	Speech/Language Evaluation	01	$XX.XX
92507		3	1	Speech/Language Therapy	17	$XXX.XX
92508		3	1	Group Speech/Language Therapy	17	$XXX.XX
				TOTAL CHARGE	21	$XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YYYY (DATE)
24 I.M. Provider (REQUESTING PROVIDER SIGNATURE)
Begin MM/DD/YYYY

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:
☐ APPROVED
GRANT DATE
EXPIRATION DATE
PROCEDURE(S) AUTHORIZED
QUANTITY AUTHORIZED
☐ MODIFIED – REASON:
☐ DENIED – REASON:
☐ RETURN – REASON:

DO NOT write in this space.
Reserved for Medicaid use.

DATE
CONSULTANT/ANALYST SIGNATURE

482-120

Appendix 6

Prior Authorization/Therapy Attachment (PA/TA) Completion Instructions (Speech and Language Pathology)

(A copy of the Prior Authorization / Therapy Attachment [PA/TA] Completion Instructions [Speech and Language Pathology] is located on the following pages.)

PRIOR AUTHORIZATION/THERAPY ATTACHMENT COMPLETION INSTRUCTIONS

The Wisconsin Medicaid program requires information to enable the Medicaid program to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information shall include but is not limited to information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02 (4), Wis. Admin. Code).

Under s. 49.45 (4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to the Medicaid program administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

Each provider must submit sufficient detailed information. Sufficient detailed information on a PA request means enough clinical information regarding the recipient to meet Wisconsin Medicaid's definition of "medically necessary." "Medically necessary" is defined in HFS 101.03(96m), Wis. Admin. Code. Each PA request is unique, representing a specific clinical situation. Therapists typically consider a number of issues that influence a decision to proceed with therapy treatment at a particular frequency to meet a particular goal. Those factors that influence treatment decisions should be documented on the PA request. Medicaid therapy consultants will consider documentation of those same factors to determine whether or not the request meets Wisconsin Medicaid's definition of "medically necessary." Medicaid consultants cannot "fill in the blanks" for a provider if the documentation is insufficient or unclear. The necessary level of detail may vary with each PA request and within the various sections of a PA request.

These directions are formatted to correspond to each required element on the Prior Authorization Therapy Attachment (PA/TA). The bold headers directly reflect the name of the element on the PA/TA. The proceeding text reflects instructions, hints, examples, clarification, etc., that will help the provider document medical necessity in sufficient detail.

Attach the completed Prior Authorization Therapy Attachment (PA/TA) to the Prior Authorization Request Form (PA/RF) and submit to the following address:

Wisconsin Medicaid
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

SECTION A. RECIPIENT / PROVIDER INFORMATION

Enter the following information into the appropriate box:

1. **Recipient's Name — Last, First and MI**
   Enter the recipient's last name, first name, and middle initial. Use Wisconsin Medicaid's Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or the spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS. Refer to the Provider Resources section of the All-Provider Handbook for ways to access the EVS.
2. **Recipient's Medicaid ID Number**
   Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.
3. **Recipient's Age**
   Enter the age of the recipient in numerical form (e.g., 16, 21, 60).
4. **Therapist's Name & Credentials**
   Enter the treating therapist's name and credentials. If the treating therapist is a therapy assistant, enter the name of the supervising therapist and the name of the therapy assistant.

5. **Therapist's Medicaid Provider Number**
   Enter the treating therapist's eight-digit Medicaid provider number. If the treating therapist is the therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider number.

6. **Therapist's Telephone Number**
   Enter the treating therapist's telephone number, including area code and extension (if applicable). If the treating therapist is a therapy assistant, enter the telephone number of the supervising therapist.

7. **Referring/Prescribing Physician's Name**
   Enter the referring or prescribing physician's name.

   Be sure:

   - The recipient's name and Medicaid identification number match.
   - The recipient's Medicaid identification number has 10 digits.
   - The recipient is currently Medicaid eligible.
   - The provider's name and Medicaid identification number match.
   - The provider's Medicaid number has eight digits.

   HINT: All of this information in this section must be complete, accurate, and exactly the same as the information from Medicaid's EVS and on the Prior Authorization Request Form (PA/RF) before your PA request is forwarded to a Medicaid consultant. Incomplete or inaccurate information will result in a returned PA request.

8. **Requesting Prior Authorization (PA) For Physical Therapy Occupational Therapy Speech Therapy**
   Check the appropriate box on the PA/TA for the type of therapy service being requested.

9. **Total Time Per Day Requested**
   Enter the anticipated number of minutes a typical treatment session will require. It is expected the requested minutes per session will be consistent with the recipient's history, age, attention span, cognitive ability, medical status, treatment goals, procedures, rehabilitation potential and any other intervention the recipient receives. Intensity of intervention is determined by rate of change, rather than level of severity.

10. **Total Sessions Per Week Requested**
    Enter the number of treatment days per week requested. It is expected the requested number of treatment days per week will be consistent with the recipient's history, medical status, treatment goals, rehabilitation potential and any other intervention the recipient receives. Intensity of intervention is determined by rate of change, rather than level of severity.

11. **Total Number of Weeks Requested**
    Enter the number of weeks requested. The requested duration should be consistent with the recipient's history, medical status, treatment goals, rehabilitation potential and any other intervention the recipient receives. The requested duration SHOULD CORRESPOND TO THE NUMBER OF WEEKS REQUIRED TO REACH THE GOALS IDENTIFIED IN THE PLAN OF CARE. Intensity of intervention is determined by rate of change, rather than level of severity.

12. **Requested Start Date**
    Enter the requested grant date for this PA request in MM/DD/YYYY format.

SECTION B. PERTINENT DIAGNOSES / PROBLEMS TO BE TREATED

INSTRUCTIONS: Provide a description of the recipient's current treatment diagnosis, any underlying conditions, and problem(s) to be treated, including dates of onset.

Indicate the pertinent medical diagnoses that relate to the reasons for providing therapy for the recipient at this time AND any underlying conditions that may affect the plan of care or outcome (e.g., dementia, cognitive impairment,

medications, attention deficits). Include dates of onset for all diagnoses. If the date of onset is unknown, state "unknown."

If this documentation is on a previous PA request and is still valid, indicate "this documentation may be found on PA No. XXXXXXX." Providers should review this information for accuracy each time that they submit a PA request.

HINT: Avoid copying the same information on subsequent PA requests without verifying that the information continues to be accurate. A PA request may be returned if it appears as if there has been no change documented under Section B, but other sections of the PA suggest there have been some changes to the recipient's medical/ functional condition/need.

Example 1: A recipient without cognitive impairment may attain a goal to learn a task in one to three visits. However, achieving the same treatment goal for a cognitively impaired recipient may require additional visits. Knowledge of the recipient's cognitive abilities is critical to understanding the need for the requested additional visits.

Example 2: When the recipient has a medical diagnosis, such as Parkinson's disease or pervasive developmental disorder, it is necessary to document the medical diagnosis AS WELL AS the problem(s) being treated. Listing problem(s) to be treated without a medical diagnosis, or vice versa, is insufficient.

SECTION C. BRIEF PERTINENT MEDICAL / SOCIAL INFORMATION

INSTRUCTIONS: Include referral information, living situation, previous level of function, any change in medical status since previous PA request(s), and any other pertinent information.

The Medicaid consultant needs to understand the complete "picture" of the recipient and takes into consideration the recipient's background, personal needs, status, change in status, etc. Sufficient, but pertinent, documentation of a recipient's medical/social status may include:

- Conditions that may affect the recipient's outcome of treatment.
- Evidence that this recipient will benefit from therapy at this time.
- Reasons why a Medicaid-reimbursed service is being requested at this time (this is helpful when this is not a new diagnosis or is a continuing episode of care for this recipient).

The provider's documentation must include the factors considered when developing the recipient's plan of care. Such factors may be:

- Reasons for referral.
- Referral source (e.g., a second opinion, nursing having difficulty with carryover program, school therapist referred because school does not have equipment to make orthotics).
- Reason(s) the recipient's medical needs are not met under current circumstances.
- Recent changes (e.g., change in medical status, change in living status) with reference dates.
- Recipient's goal (e.g., recipient's motivation to achieve a new goal may have changed).
- Recipient's living situation.
- Residence (e.g., nursing home vs. independent living).
- Caregiver (who is providing care [specific name not required], how frequently available, ability to follow through with instructions, etc.).
- If caregiver is required — the level of assistance required, the amount of assistance required, the type of assistance required.
- Degree of family support.
- Equipment and/or environmental adaptations used by the recipient.
- Brief history of the recipient's previous functional status.
- Prior level of function.
- Level of function after last treatment episode with reference dates.
- Cognition/behavior/compliance.
- Any other pertinent information that indicates a need for therapy services at this time.

SECTION D. PERTINENT THERAPY INFORMATION

1. **INSTRUCTIONS: Document the chronological history of treatment provided for the treatment diagnoses (identified under "B"), dates of those treatments, and the recipient's functional status following those treatments.**
   Summarize previous episodes of care, if applicable, in the chart provided in this section. If this is a new patient, include history taken from the recipient, recipient's caregivers, or patient file. Include knowledge of other therapy services provided to the recipient (e.g., if requesting a PA for speech and language pathology [SLP], include any occupational therapy [OT] or physical therapy [PT] the recipient may have received as well). Be concise, but informative.

2. **INSTRUCTIONS: List other service providers that are currently accessed by the recipient for treatment diagnoses identified under "B," (i.e., home health, school, behavior management, home program, dietary services, therapies). Briefly document the coordination of the therapy treatment plan with these other service providers. Documentation may include telephone logs, summarization of conversations/written communication, copies of plans of care, staffing reports, received written reports, etc.**
   Document the coordination of the therapy treatment plan with other service providers that may be working to achieve the same, or similar, goals for the recipient. If there are no other providers currently treating the recipient, indicate "not applicable" in the space provided.

3. **INSTRUCTIONS: Check the appropriate box (on the PA/TA) and circle the appropriate form, if applicable:**

   - ☐ **The current Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP)/Individual Program Plan (IPP) is attached to this PA request.**
   - ☐ **The current IEP/IFSP/IPP is attached to PA Number_____.**
   - ☐ **There is no IEP/IFSP/IPP because _____.**
   - ☐ **Cotreatment with another therapy provider is within the plan of care.**
   - ☐ **Referenced report(s) is attached (list any report[s])_____.**

   The IEP, IFSP, and IPP are reports used as follows:

   - Individualized Education Plan — A written plan for a 3- to 21-year-old child who receives exceptional education services in school.
   - Individualized Family Service Plan — A written plan for a 0- to 3-year-old child who receives therapy services through the Birth to 3 Program.
   - Individualized Program Plan — A written active treatment plan for individuals who reside in an Intermediate Care Facility for the Mentally Retarded (ICF-MR).

   Submission of the IEP, IFSP, and IPP with the PA request is required if the recipient is receiving services that require one of the above written plans.

   This section is included as a quick reference to remind the provider to attach the necessary documentation materials to the PA request and to remind providers to document cotreatment, if applicable, in their plan of care.

   Cotreatment is when two therapy types provide their respective services to one recipient during the same treatment session. For example, OT and PT treat the patient at the same time or OT and SLP treat the recipient at the same time. It is expected the medical need for cotreatment be documented in both providers' plans of care and both PA requests are submitted in the same envelope.

   Other "referenced reports" may be swallow studies, discharge summaries, surgical reports, dietary reports, psychology reports, etc. These reports should be submitted with the PA request when the information in those reports influenced the provider's treatment decision making and were referenced elsewhere in the PA request.
   PA requests submitted without the required or referenced documentation attached to the PA request will be returned to the provider.

SECTION E. EVALUATION (COMPREHENSIVE RESULTS OF FORMAL / INFORMAL TESTS AND MEASUREMENTS THAT PROVIDE A BASELINE FOR THE RECIPIENT'S FUNCTIONAL LIMITATIONS)

INSTRUCTIONS: Attach a copy of the initial evaluation, or the most recent evaluation or re-evaluation; or indicate with which PA number this information was previously submitted.

- ☐ **Comprehensive initial evaluation attached. Date of initial comprehensive evaluation _____.**
- ☐ **Comprehensive initial evaluation submitted with PA number _____.**
- ☐ **Current re-evaluation attached. Date of most current evaluation or re-evaluation(s) _____.**
- ☐ **Current re-evaluation submitted with PA number _____.**

A copy of the comprehensive evaluation for the current episode of care (for the current problem being treated) must be included with the PA request or submitted previously with another PA request, regardless of when treatment was initiated, and regardless of the reimbursement source at the time of the comprehensive evaluation. An evaluation defining the recipient's overall functional abilities and limitations with baseline measurements, from which a plan of care is established, is necessary for the Medicaid consultant to understand the recipient's needs and the request.

The initial evaluation must:

(1) Establish a baseline for identified limitations — Provide baseline measurements that establish a performance (or ability) level, using units of objective measurement that can be consistently applied when reporting subsequent status. It is very important to use consistent units of measurement throughout documentation, or be able to explain why the units of measurement changed.

Example 1: If the functional limitation is "unable to brush teeth," the limiting factor may be due to strength, range of motion, cognition, sensory processing, equipment needs, etc. The baseline should establish the status of identified limiting factors. Such factors may include:

- Range of motion measurements in degrees;
- Eye-hand coordination as measured by a testing tool or units of speed and accuracy;
- Oral sensitivity as measured by an assessment tool or type of reaction to specific kinds of textures, temperatures at specific oral cavity/teeth location;
- Grasp deficits including type of grasp and grip strength.

Later on, subsequent progress must be described using the same terms (e.g., grip strength increased by 2 pounds).

Example 2: If the functional limitation is "unable to sit long enough to engage in activities," indicate "the recipient can short sit for two minutes, unsupported, before losing his balance to the left." Later on, progress can be documented in terms of time.

(2) Relate the functional limitations to an identified deficit — The evaluation must be comprehensive enough that another, independent, clinician would reasonably reach the same conclusion regarding the recipient's functional limitation.

Example 1: The recipient is referred to therapy because "she doesn't eat certain types of foods." The evaluation should clearly indicate the reason for not eating those certain foods. A deficit has not been identified if testing indicates the recipient only eats Food "B." Some deficit examples (for not eating a variety of foods) are: cleft palate, oral defensiveness, lip closure, tongue mobility, an aversion to food, aspiration, attention span, recipient is G-tube fed and is therefore not hungry. The identified deficit must be objectively measured and quantified (i.e., a baseline — see above).

Example 2: The recipient is referred to therapy because "he cannot go up and down stairs safely." The evaluation should clearly indicate the reasons for this functional limitation. A deficit has not been identified if the results of testing indicate the recipient can only step up three inches. Strength, range of motion,

balance, sensory processing, motivation, etc., must be assessed and documented to identify the deficit causing the functional limitation (objectively tested, measured, and quantified on the evaluation).

A re-evaluation is the process of performing selected tests and measures (after the initial evaluation) in the targeted treatment area(s) to evaluate progress, functional ability, treatment effectiveness, and/or to modify or redirect intervention. The re-evaluation must be submitted with the PA request whenever it is necessary to update the recipient's progress/condition. Use of the same tests and measurements as used in the initial evaluation is essential to review status/progress. If new tests or measurements are used in the re-evaluation, explain why a different measurement tool was used.

SECTION F. PROGRESS

INSTRUCTIONS: Describe progress in specific, measurable, objective, and functional terms (using consistent units of measurement) that are related to the goals/limitations, since treatment was initiated or last authorized.

(If this information is concisely written in other documentation prepared for your records, attach and write "see attached" in the space.)

Document the goal or functional limitation in the left column on the PA/TA. Indicate the corresponding status for that goal or limitation as of the previous PA request or since treatment was initiated (whichever is most recent) in the middle column on the PA/TA. Indicate the corresponding status of that goal or limitation as of the date of the current PA request (do not use "a month ago" or "when last seen" or "when last evaluated") in the third column of the PA/TA. Progress relates to the established baseline, previous goals, and identified limitations. Use the same tests and measurements as those units of measurement used in the baseline description.

The following information is necessary to evaluate the medical necessity of the PA request:

- Progress documented in specific, measurable, objective terms.
- Use of words that are specific, measurable, or objective such as: better, improved, calmer, happier, pleasant, less/more, not as good, not as reliable, longer, more prolonged, and "goal not met" are not specific, measurable, or objective. These do not convey to the Medicaid consultant if or how much progress has been achieved. The following examples are specific, measurable, and objective:

  Example 1: Strength increased from POOR to FAIR, as determined with a Manual Muscle Test.

  Example 2: Speech intelligibility improved from 30% to 70%, per standardized measurement.

- Consistent use of the same tests and measurements and units of measurement.

  Example: A progress statement that notes the recipient can now eat hamburgers does not correlate to his goal of articulation and the baseline established for articulation.

- Progress must demonstrate the recipient has learned new skills and therefore has advanced or improved in function as a result of treatment intervention. "If treatment of underlying factors, such as increase in endurance, strength or range of motion or decrease in pain does not improve the performance of functional activities, then improvement is not considered to be significant." (Acquaviva, p. 85).

  "Significant functional progress: Must result from treatment rather from maturation or other uncontrolled factors, must be real, not random, must be important, not trivial" (Bain and Dollaghan).
  - Significant functional progress must have been demonstrated within the past six months for continued therapy PA approval. Prior authorization requests for treatment that has not advanced or improved function within six months cannot be approved, HFS 107.16(3)(e)1, HFS 107.17(3)(e)1, and HFS 107.18(3)(e)1, Wis. Admin. Code.
  - Prior authorization requests for maintenance therapy must demonstrate the functional purpose (medical necessity) of treatment, as "progress" is not necessarily applicable to maintenance programs. The Medicaid consultant will look for evidence that there is a continued functional purpose for the recipient as a result of skilled therapeutic intervention, in accordance with the Wisconsin Administrative Code and the July 2000 *Wisconsin Medicaid and BadgerCare Update* (2000-24), titled "Prior Authorization for Maintenance Therapy."

SECTION G. PLAN OF CARE

INSTRUCTIONS: Identify the specific, measurable, objective, and functional goals for the recipient (to be met by the end of this PA request); and
(1) the therapist required skills/treatment techniques that will be used to meet each goal; and
(2) designate (with an asterisk[*]) which goals are reinforced in a carry-over program.

(If the plan of care is concisely written in other documentation prepared for the recipient's records, attach and write "see attached" in the space provided.)

Examples for this section include:
1. GOAL: Client will be 80% intelligible in conversation as judged by an unfamiliar listener.
   POC: Oral motor exercises, environmental cues, articulation skills.
2. GOAL: Client will increase vocabulary with five new words as reported by parent.
   POC: Sing songs, read books, use adjectives and adverbs in conversation.*
3. GOAL: Client will ascend stairs reciprocally without assistance.
   POC: Gastrocnemius and gluteus medius strengthening.
4. GOAL: Client will transfer into and out of tub with verbal cues.
   POC: Prepare bathroom and client for transfer, provide consistent verbal cues as rehearsed in PT.*
5. GOAL: Client will demonstrate ability to button ½-inch button on dress shirt independently using any pinch pattern.
   POC: Graded finger grasp/pinch strengthening, eye-hand coordination, and bilateral hand use.
6. GOAL: Client will catch/throw a 10" ball.
   POC: Practice play catch while sitting using a variety of objects, e.g., Nerf® ball, plastic ball, beach ball, volleyball, balloon.*

It is very important to:
- Use consistent units of measurement.
- Document those elements of a treatment plan that only a skilled therapist could implement (e.g., 1, 3, and 5 above)
- Designate (with an asterisk [*]) those goals or interventions the provider has instructed other caregivers or the recipient to incorporate into the recipient's usual routine in his or her usual environment (such as 2, 4, and 6 above where kicking a ball, jumping, throwing a ball, building endurance, rote activities, who/what/where questions, using appropriate pronouns, choosing new foods, etc., are part of the overall plan of care).
- Write goals consistent with functional limitations and identified deficit as described in the evaluation and status statements (Section E) or progress section (Section F).

  Example: The evaluation identified the functional limitation and deficits corresponding to the above examples.
  Examples of limitations and deficits may include:
  1. The client is not intelligible in conversation due to poor tongue control.
  2. The 24-month-old client cannot express his needs because he has the vocabulary of a 16-month-old.
  3. The client cannot get to his bedroom independently because of POOR muscle strength.
  4. The client cannot safely get into the bathtub because he has poor short-term memory and is easily distractible.
  5. The client cannot dress independently because of decreased fine-motor skills as tested on the Peabody and he lacks all functional pinch patterns.
  6. The client cannot use hands/arms bilaterally because of poor left upper-extremity proximal stability.

SECTION H. REHABILITATION POTENTIAL

INSTRUCTIONS: Complete the following sentences based upon the professional assessment.

(1) Upon discharge from this episode of care, the recipient will be able to

Describe what the recipient will be able to FUNCTIONALLY DO at the end of this episode of care (not necessarily the end of the PA request), based upon the professional assessment. Discharge planning begins at the initial evaluation. At the initial evaluation the therapist should be able to determine the amount/type of change the recipient is capable of making based upon all the factors presented at the evaluation. Statements such as "will be age appropriate," "will resume prior level of function," "will have effects of multiple sclerosis minimized," or "will eat all foods" are vague and frequently are not achievable with the patient population therapists encounter. More recipient specific or definitive statements of prognosis would be the following examples:

- "Return to home to live with spouse support."
- "Communicate basic needs and wants with her peers."
- "Go upstairs to his bedroom by himself."
- "Get dressed by herself."
- "Walk in the community with stand-by assistance for safety."
- "Walk to the dining room with or without assistive device and the assistance of a nurse's aide."
- "Swallow pureed foods."

(2) Upon discharge from this episode of care, the recipient may continue to require the following supportive services

Indicate what community or therapy services the recipient may continue to require at the end of this episode of care. Examples include:

- "Range of motion program by caregivers."
- "Infrequent (be specific) screening by therapist to assure maintenance of skills."
- "A communication book."
- "Behavior management services."
- "Dietary consultation."
- "Supervision of <a task> by a caregiver."

(3) The recipient/recipient's caregivers support the therapy plan of care by the following activities and frequency of carryover

Describe what activities the recipient and/or caregivers do/do not do with the recipient that will affect the outcome of treatment.

(4) It is estimated this episode of care will end (provide approximate end time)

Establish an anticipated time frame for the recipient to meet his/her realistic functional goals (e.g., two weeks, two months, two years).

These specific questions are asked to avoid one-word responses (e.g., "good"). Information beyond a one-word response provides the Medicaid consultant with additional detail that supports the justification that therapy services are necessary to meet the recipient's goals. Wisconsin Medicaid recognizes the statements in this section are considered professional judgments and may not reflect the actual outcome of treatment.

SIGNATURES

The request must be accompanied by a physician's signature (a copy of the physician's order sheet dated within 90 days of its receipt by Wisconsin Medicaid indicating the physician's signature is acceptable). The providing therapist's signature is required at the end of the PA/TA. The recipient's, or recipient's caregiver's, signature is optional at this time, but is encouraged (as a means to review what has been requested on the recipient's behalf on the PA request).

If the required documentation is missing from the request form, the request is returned to the provider for the missing information.

REMINDER: The prior authorization request must be filled out completely (i.e., all sections completed). Attach the completed PA/TA and any other documentation to the PA/RF.

REFERENCES

Bain and Dollaghan (1991). Language, Speech and Hearing Services in Schools, 13

Acquaviva, J.D., ed. (1992). Effective Documentation for Occupational Therapy. Rockville, Maryland, The American Occupational Therapy Association, Inc.

Moyers, P.A. (1999). “The Guide to Occupational Therapy Practice.” American Journal of Occupational Therapy (Special Issue), 53 (3)

American Physical Therapy Association, 2001, Guide to Physical Therapist Practice, Physical Therapy, 81 (1)

American Physical Therapy Association, 1997, Guide to Physical Therapist Practice, Physical Therapy, 77 (11)

American Speech-Language and Hearing Association, 1997, Cardinal Documents

American Occupational Therapy Association Standards of Practice

American Physical Therapy Association Standards of Practice

American Speech-Language and Hearing Association Standards of Practice

Wisconsin Administrative Code

Appendix 7

Sample Prior Authorization/Therapy Attachment (PA/TA) (Speech and Language Pathology)

(A sample copy of the Prior Authorization / Therapy Attachment [PA/TA] [Speech and Language Pathology] is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11008 (Rev. 01/02)

STATE OF WISCONSIN
(800) 947-9627

PRIOR AUTHORIZATION / THERAPY ATTACHMENT

SECTION A. RECIPIENT / PROVIDER INFORMATION

1. Recipient's Name — Last	First	MI	2. Recipient's Medicaid ID Number	3. Recipient's Age
Recipient	Ima	A	1234567890	2

4. Therapist's Name & Credentials	5. Therapist's Medicaid Provider No.	6. Therapist's Telephone No.
I.M. Performing, MS, CCC-SLP	12345678	(XXX) XXX-XXXX

7. Referring / Prescribing Physician's Name	8. Requesting Prior Authorization (PA) For
I.M. Referring/Prescribing	☐ Physical Therapy ☐ Occupational Therapy ☒ Speech Therapy

9. Total Time Per Day Requested	10. Total Sessions Per Week Requested
60 minutes	2X

11. Total Number of Weeks Requested	12. Requested Start Date
17	06/01/03

SECTION B. PERTINENT DIAGNOSES / PROBLEMS TO BE TREATED

INSTRUCTIONS: Provide a description of the recipient's current treatment diagnosis, any underlying conditions, and problem(s) to be treated, including dates of onset.

Female has a diagnosis of cerebral palsy. She also has seizure disorders and exhibits delays in all areas of development. Onset birth. Female has limited vocabulary.

SECTION C. BRIEF PERTINENT MEDICAL / SOCIAL INFORMATION

INSTRUCTIONS: Include referral information, living situation, previous level of function, any change in medical status since previous PA request(s), and any other pertinent information.

Female is a twin, born at 24.5 wks. gestation. She was hospitalized for four months following birth. She was ventilator-dependent for eight weeks. Recipient resides at home with twin brother, parents and two older siblings. Seizures are controlled with medication. Vision and hearing tested in January 2003 and judges to be within normal limits. She wears bilateral night splints and bilateral ankle foot orthotics.

SECTION D. PERTINENT THERAPY INFORMATION

1. INSTRUCTIONS: Document the chronological history of treatment for the diagnoses (identified under Section B), dates of those treatments, and the recipient's functional status following those treatments.

Provider Type (e.g., OT, PT, ST)	Dates of Treatment	Functional Status after Treatment
PT	1/2/XX to 1/11/XX	LE ROM, muscle tone, trunk central positioning.
OT	1/2/XX to 1/11/XX	UE ROM, splinting, ADL, NDT.
ST	1/2/XX to 1/11/XX	gestures, expressive language, receptive language.

2. INSTRUCTIONS: List other service providers that are currently accessed by the recipient for those treatment diagnoses identified under "B", (i.e., home health, school, behavior management, home program, dietary services, therapies). Briefly document the coordination of the therapy treatment plan with these other service providers. Documentation may include phone logs, summarization of conversations/written communication, copies of plans of care, staffing reports, received written reports, etc.

3. INSTRUCTIONS: Check the appropriate box and circle the appropriate form, if applicable.

- ☐ The current Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP)/Individual Program Plan (IPP) is attached to this PA request.
- ☐ The current IEP/IFSP/IPP is attached to PA Number _____.
- ☒ There is no IEP/IFSP/IPP because Family has chosen not to receive speech services through the Birth to 3 program.
- ☐ Co-treatment with another therapy provider is within the plan of care.
- ☐ Referenced report(s) is attached (list any report[s]) _____.

SECTION E. EVALUATION (COMPREHENSIVE RESULTS OF FORMAL / INFORMAL TESTS AND MEASUREMENTS THAT PROVIDE BASELINE FOR THE RECIPIENT'S FUNCTIONAL LIMITATIONS)

INSTRUCTIONS: Attach a copy of the initial evaluation, or the most recent evaluation or re-evaluation; or indicate with which PA number this information was previously submitted.

- ☐ Comprehensive initial evaluation attached. Date of initial comprehensive evaluation _____.
- ☒ Comprehensive initial evaluation submitted with PA number 123456.
- ☒ Current re-evaluation attached. Date of most current evaluation or re-evaluation(s) MM/DD/YY.
- ☐ Current re-evaluation submitted with PA number _____.

SECTION F. PROGRESS

INSTRUCTIONS: Describe progress in specific, measurable, objective, and functional terms (using consistent units of measurement) that are related to the goals/limitations, *since treatment was initiated or last authorized*.

Goal / Limitation	Previous Status / Date (/ /)	Status as of Date of PA Request / Date (/ /)
Expressive language Recipient will spontaneously use sound approximations during a 15-minute play activity with peers as tallied by the speech-language pathologist.	Was imitating sounds during play activities, such as car noises, animal noises, 30%	Now spontaneously uses sounds 100% during play activities and consistently imitates single-word approximations during play activities.
Expressive language/gestures Recipient will spontaneously sign 10X as tallied by the speech-language pathologist during a 60-minute individual therapy session.	Was using sign language to only communicate three signs . . . "more," "me," and "eat."	Now spontaneously pairs appropriate word approximations with the signs "more," "me," and "eat." In addition, three signs have been added to the recipient's repertoire: "dog," "drink," and "home."
Receptive language Recipient will follow two-step directions with 90% accuracy.	Was following two-step commands during routine activities with 75% accuracy and novel two-step directions with 30% accuracy.	Now follows two-step commands during routine activities with 95% accuracy and novel two-step directions with 75% accuracy.

(If this information is concisely written in other documentation prepared for your records, attach and write "see attached" in the space above.)

Prior Authorization / Therapy Attachment
HCF 11008 (Rev. 01/02)

SECTION G. PLAN OF CARE

INSTRUCTIONS: Identify the specific, measurable, objective, and functional goals for the recipient (to be met by the end of this PA request); and

(1) the therapist required skills/treatment techniques that will be used to meet each goal; and
(2) designate (with an asterisk [*]) which goals are reinforced in a carry-over program.

Expressive language — Long-Term Goal: Recipient will spontaneously use words to communicate.

1. Recipient will spontaneously use ten single-word approximations during a 15-minute play activity with peers as tallied by the speech-language pathologist.*
2. When using sign language, the recipient will spontaneously pair word approximations with 75% of the signs tallied by the speech-language pathologist, during a 20-minute individual therapy session.*
3. Recipient will increase the number of spontaneous signed words from six to 10 as observed by the speech-language pathologist during group therapy at the day care or individual therapy sessions and as reported by the recipient's mother.*

Receptive language — Long-Term Goal: Recipient's mother will report recipient follows directions in various environments with little verbal redirection.

1. Recipient will follow novel, two-step directions during 90% of opportunities for three consecutive therapy sessions (group or individual) as tallied by the speech-language pathologist.*

(If the plan of care is concisely written in other documentation prepared for the recipient's records, attach and write "see attached" in the space above.)

SECTION H. REHABILITATION POTENTIAL

INSTRUCTIONS: Complete the following sentences based upon the professional assessment.

(1) Upon discharge from this episode of care, the recipient will be able to

Communicate using gestures and some words.

(2) Upon discharge from this episode of care, the recipient may continue to require the following supportive services

Early childhood intervention or speech-language therapy to continue building language.

(3) The recipient/recipient's caregivers support the therapy plan of care by the following activities and frequency of carryover

Services are provided in the home or day care. The parents or the day care provider participates in each session and incorporates treatment activities into the child's play activities and daily routines.

(4) It is estimated this episode of care will end (provide approximate end time)

This episode of care will end in approximately five months when the child turns three and transitions to the school district's early childhood program. The child continues to demonstrate significant objective, measurable progress as a result of therapy. Discharge at this time is not appropriate.

SIGNATURE – Physician	Date Signed
I.M. Provider	MM/DD/YYYY
SIGNATURE – Providing Therapist	Date Signed
I.M. Provider	MM/DD/YYYY
SIGNATURE – Recipient or Recipient Caregiver (optional)	Date Signed

Appendix 8

Prior Authorization/Therapy Attachment (PA/TA) (for photocopying)

(A copy of the Prior Authorization / Therapy Attachment [PA/TA] is located on the following pages.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11008 (Rev. 01/02)

STATE OF WISCONSIN
(800) 947-9627

PRIOR AUTHORIZATION / THERAPY ATTACHMENT

SECTION A. RECIPIENT / PROVIDER INFORMATION

1. Recipient's Name — Last	First	MI	2. Recipient's Medicaid ID Number	3. Recipient's Age

4. Therapist's Name & Credentials	5. Therapist's Medicaid Provider No.	6. Therapist's Telephone No.

7. Referring / Prescribing Physician's Name	8. Requesting Prior Authorization (PA) For
	☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

9. Total Time Per Day Requested	10. Total Sessions Per Week Requested

11. Total Number of Weeks Requested	12. Requested Start Date

SECTION B. PERTINENT DIAGNOSES / PROBLEMS TO BE TREATED

INSTRUCTIONS: Provide a description of the recipient's current treatment diagnosis, any underlying conditions, and problem(s) to be treated, including dates of onset.

SECTION C. BRIEF PERTINENT MEDICAL / SOCIAL INFORMATION

INSTRUCTIONS: Include referral information, living situation, previous level of function, any change in medical status since previous PA request(s), and any other pertinent information.

SECTION D. PERTINENT THERAPY INFORMATION

1. INSTRUCTIONS: Document the chronological history of treatment for the diagnoses (identified under Section B), dates of those treatments, and the recipient's functional status following those treatments.

Provider Type (e.g., OT, PT, ST)	Dates of Treatment	Functional Status after Treatment

Appendix

2. INSTRUCTIONS: List other service providers that are currently accessed by the recipient for those treatment diagnoses identified under "B", (i.e., home health, school, behavior management, home program, dietary services, therapies). Briefly document the coordination of the therapy treatment plan with these other service providers. Documentation may include phone logs, summarization of conversations/written communication, copies of plans of care, staffing reports, received written reports, etc.

3. INSTRUCTIONS: Check the appropriate box and circle the appropriate form, if applicable.

- ☐ The current Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP)/Individual Program Plan (IPP) is attached to this PA request.
- ☐ The current IEP/IFSP/IPP is attached to PA Number _____.
- ☐ There is no IEP/IFSP/IPP because _____.
- ☐ Co-treatment with another therapy provider is within the plan of care.
- ☐ Referenced report(s) is attached (list any report[s]) _____.

SECTION E. EVALUATION (COMPREHENSIVE RESULTS OF FORMAL / INFORMAL TESTS AND MEASUREMENTS THAT PROVIDE BASELINE FOR THE RECIPIENT'S FUNCTIONAL LIMITATIONS)

INSTRUCTIONS: Attach a copy of the initial evaluation, or the most recent evaluation or re-evaluation; or indicate with which PA number this information was previously submitted.

- ☐ Comprehensive initial evaluation attached. Date of initial comprehensive evaluation _____.
- ☐ Comprehensive initial evaluation submitted with PA number _____.
- ☐ Current re-evaluation attached. Date of most current evaluation or re-evaluation(s) _____.
- ☐ Current re-evaluation submitted with PA number _____

SECTION F. PROGRESS

INSTRUCTIONS: Describe progress in specific, measurable, objective, and functional terms (using consistent units of measurement) that are related to the goals/limitations, *since treatment was initiated or last authorized.*

Goal / Limitation	Previous Status / Date (/ /)	Status as of Date of PA Request / Date (/ /)

(If this information is concisely written in other documentation prepared for your records, attach and write "see attached" in the space above.)

SECTION G. PLAN OF CARE

INSTRUCTIONS: Identify the specific, measurable, objective, and functional goals for the recipient (to be met by the end of this PA request); and

(1) the therapist required skills/treatment techniques that will be used to meet each goal; and
(2) designate (with an asterisk [*]) which goals are reinforced in a carry-over program.

(If the plan of care is concisely written in other documentation prepared for the recipient's records, attach and write "see attached" in the space above.)

SECTION H. REHABILITATION POTENTIAL

INSTRUCTIONS: Complete the following sentences based upon the professional assessment.

(1) Upon discharge from this episode of care, the recipient will be able to

(2) Upon discharge from this episode of care, the recipient may continue to require the following supportive services

(3) The recipient/recipient's caregivers support the therapy plan of care by the following activities and frequency of carryover

(4) It is estimated this episode of care will end (provide approximate end time)

SIGNATURE – Physician	Date Signed
SIGNATURE – Providing Therapist	Date Signed
SIGNATURE – Recipient or Recipient Caregiver (optional)	Date Signed

Reset Form

Appendix 9

Prior Authorization Request Form (PA/RF) for Spell of Illness Completion Instructions (Speech and Language Pathology)

Element 1 — Processing Type

Enter processing type 116 — Speech and language pathology (Spell of Illness [SOI] Only). The "processing type" is a three-digit code used to identify a category of service requested.

Element 2 — Recipient's Medical Assistance ID Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 3 — Recipient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 4 — Recipient Address

Enter the complete address (street, city, state, and ZIP code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 — Date of Birth

Enter the recipient's date of birth in MM/DD/YYYY format (e.g., June 30, 1975, would be 06/30/1975).

Element 6 — Sex

Enter an "X" to specify whether the recipient is male or female.

Element 7 — Billing Provider Name, Address, ZIP Code

Enter the billing provider's name and complete address (street, city, state, and ZIP code). *No other information should be entered into this element since it also serves as a return mailing label.*

Element 8 — Billing Provider Telephone Number

Enter the billing provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 — Billing Provider No.

Enter the billing provider's eight-digit Medicaid provider number.

Element 10 — Dx: Primary

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested for the recipient.

Element 11— Dx: Secondary

Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

Element 12 — Start Date of SOI

Enter the date of onset for the SOI in MM/DD/YYYY format (e.g., March 1, 2003, would be 03/01/2003).

Element 13 — First Date Rx

Enter the date of the first treatment for the SOI in MM/DD/YYYY format (e.g., March 1, 2003, would be 03/01/2003).

Element 14 — Procedure Code

Enter the appropriate Wisconsin Medicaid-assigned five-digit procedure code for each service/procedure/item requested.

Element 15 — MOD (not required)

Element 16 — POS

Enter the appropriate Medicaid single-digit place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Code	Description
0	Other
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
4	Home
7	Nursing Facility
8	Skilled Nursing Facility

Element 17 — TOS

Enter the appropriate Medicaid single-digit type of service code for each service/procedure/item requested.

Code	Description
1	Medical
9	Rehabilitation Agency

Element 18 — Description of Service

Enter a written description corresponding to the appropriate five-digit procedure code for each service/procedure/item requested.

Element 19 — QR (not required)

Element 20 — Charges (not required)

Element 21 — Total Charge (not required)

Element 22 — Billing Claim Payment Clarification Statement

An approved authorization does not guarantee payment. Reimbursement is contingent upon the recipient's and provider's eligibility at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a managed care program at the time a prior authorized service is provided, Medicaid reimbursement is only allowed if the service is not covered by the managed care program.

Element 23 — Date

Enter the month, day, and year (in MM/DD/YYYY format) the Prior Authorization Request Form (PA/RF) was completed and signed.

Element 24 — Requesting Provider Signature

The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER — THIS SPACE IS USED BY THE WISCONSIN MEDICAID CONSULTANT(S) AND ANALYST(S).

Appendix 10

Sample Prior Authorization Request Form (PA/RF) for Spell of Illness (Speech and Language Pathology)

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 116

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567892
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.
4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow St. Anytown, WI 55555
5 DATE OF BIRTH: MM/DD/YYYY
6 SEX: M [ ] F [X]
8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I. M. Provider, 1 W. Williams, Anytown, WI 55555
9 BILLING PROVIDER NO.: 10000000
10 DX: PRIMARY: 854 Intra cranial brain injury.
11 DX: SECONDARY: 784.5 Dysarthria
12 START DATE OF SOI: MM/DD/YYYY
13 FIRST DATE RX: MM/DD/YYYY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
92506		8	9	Speech/Language Evaluation		
92507		8	9	Speech/Language Therapy		
					TOTAL CHARGE	21

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YYYY (DATE) 24 I.M. Provider (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:
[ ] APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED
[ ] MODIFIED — REASON:
[ ] DENIED — REASON:
[ ] RETURN — REASON:

DO NOT write in this space.
Reserved for Medicaid use.

DATE _____ CONSULTANT/ANALYST SIGNATURE _____

482-120

Appendix 11

Prior Authorization Spell of Illness Attachment (PA/SOIA) Completion Instructions (Speech and Language Pathology)

Note: Do not use this attachment to request prior authorization (PA) to extend treatment beyond 35 treatment days for the same spell of illness (SOI); use the Prior Authorization Therapy Attachment (PA/TA).

Recipient Information

Element 1 — Last Name

Enter the recipient's last name. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — First Name

Enter the recipient's first name. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Middle Initial

Enter the recipient's middle initial. Use the EVS to obtain the correct initial of the recipient's name. If the initial on the Medicaid identification card and the EVS do not match, use the initial from the EVS.

Element 4 — Medical Assistance ID Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 5 — Age

Enter the age of the recipient in numerical form (e.g., 21, 45, 60).

Provider Information

Element 6 — Therapist's Name and Credentials

Enter the name and credentials of the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a nonbilling performing provider, enter the name of the supervising therapist.

Element 7 — Therapist's Medical Assistance Provider Number

Enter the performing provider's eight-digit provider number. If the performing provider is a nonbilling performing provider, enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider.

Element 8 — Therapist's Telephone Number

Enter the performing provider's telephone number, including the area code, of the office, clinic, facility, or place of business. If the performing provider is a nonbilling performing provider, enter the telephone number of the supervising therapist.

Element 9 — Referring/Prescribing Physician's Name

Enter the name of the physician referring/prescribing the evaluation/treatment.

Part A

Enter an "X" in the appropriate box to indicate a physical therapy, occupational therapy, or speech and language pathology SOI request.

Part B

Enter a description of the recipient's diagnosis and problems. Indicate what functional regression has occurred and what the potential is to reachieve the previous skill.

Part C

Attach a copy of the recipient's therapy plan of care, including a current dated evaluation, to the Prior Authorization Spell of Illness Attachment (PA/SOIA) before submitting the SOI request.

Part D

Enter the anticipated end date of the SOI in the space provided.

Part E

Attach the physician's dated signature on either the therapy plan of care or the copy of the physician's order sheet. Read the "Prior Authorization Statement" before signing and dating the attachment.

Part F

The signature of the prescribing physician and the date must appear in the space provided. (A signed copy of the physician's order sheet is acceptable.)

Part G

The dated signature of the therapist providing evaluation/treatment must appear in the space provided.

Appendix 12

Sample Prior Authorization Spell of Illness Attachment (PA/SOIA) (Speech and Language Pathology)

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/SOIA

PRIOR AUTHORIZATION SPELL OF ILLNESS ATTACHMENT
(Physical, Occupational, Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	Im	A	1234567890	55

PROVIDER INFORMATION

(6) THERAPIST'S NAME AND CREDENTIALS	(7) THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) THERAPIST'S TELEPHONE NUMBER
I.M. Performing, MS, CCC-SLP	87654321	(XXX)XXX-XXXX

(9) REFERRING/PRESCRIBING PHYSICIAN'S NAME: I. M. Referring

A. ☐ Physical Therapy SOI ☐ Occupational Therapy SOI ☒ Speech Therapy SOI

B. Provide a description of the recipient's diagnosis and problems.
Indicate the functional regression which has occurred and the potential to reachieve the previous skill level.

Recipient was involved in M.V.A. MM/DD/YYYY with resultant T.B.I. with coma and multiple internal injuries. Dysarthria, word-finding difficulty, short-term memory problems, and dysphagia were present. Acute hospitalization and follow-up rehabilitation on MM/DD/YYYY. Recipient was discharged home to live with his wife on MM/DD/YYYY. Upon discharge, the recipient was judged to be 80% intelligible during conversation, continued to have minimal word-finding difficulty, relied on a daily calendar to maintain appointments, and ate a general diet with thin liquids. Nine months later, a general regression in his ability to perform self-care was noted. His wife reported significantly slurred speech, spillage of food during meals, and coughing minutes after eating. He was admitted to this nursing facility for the purpose of regaining functional abilities.

C. Attach a copy of the recipient's Therapy Plan of Care, including a current evaluation.
See Attached

D. What is the anticipated end date of the spell of illness?
MM/DD/YYYY

E. Supply the physician's dated signature on either the Therapy Plan of Care or the Physician's Order Sheet.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

F. _____ (Signature of Prescribing Physician (A copy of the Physician's Order Sheet is acceptable)) _____ (Date)

G. I.M. Provider (Signature of Therapist Providing Evaluation/Treatment) MM/DD/YYYY (Date)

Appendix 13

Prior Authorization Spell of Illness Attachment (PA/SOIA) (for photocopying)

(A copy of the Prior Authorization Spell of Illness Attachment [PA/SOIA] is located on the following page.)

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/SOIA

PRIOR AUTHORIZATION
SPELL OF ILLNESS ATTACHMENT
(Physical, Occupational, Speech Therapy)

1. Complete this form
2. Attach to PA/RF
   (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1)	(2)	(3)	(4)	(5)
LAST NAME	FIRST NAME	MIDDLE INITIAL	MEDICAL ASSISTANCE ID NUMBER	AGE

PROVIDER INFORMATION

(6)	(7)	(8)
THERAPIST'S NAME AND CREDENTIALS	THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	( ) - THERAPIST'S TELEPHONE NUMBER

(9) REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. ☐ Physical Therapy SOI ☐ Occupational Therapy SOI ☐ Speech Therapy SOI

B. Provide a description of the recipient's diagnosis and problems.
Indicate the functional regression which has occurred and the potential to reachieve the previous skill level.

C. Attach a copy of the recipient's Therapy Plan of Care, including a current evaluation.

D. What is the anticipated end date of the spell of illness?

E. Supply the physician's dated signature on either the Therapy Plan of Care or the Physician's Order Sheet.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

F. _____ Signature of Prescribing Physician (A copy of the Physician's Order Sheet is acceptable) _____ Date

G. _____ Signature of Therapist Providing Evaluation/Treatment _____ Date

Reset Form

Appendix 14

Prior Authorization Request Form (PA/RF) Completion Instructions to Be Submitted with the Prior Authorization/Birth to 3 Therapy Attachment (PA/B3)

Element 1 — Processing Type

Enter the appropriate three-digit processing type from the list below. The "processing type" is a three-digit code used to identify a category of service requested.

160 — Physical Therapy
161 — Occupational Therapy
162 — Speech and Language Pathology

Element 2 — Recipient's Medical Assistance ID Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 3 — Recipient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 4 — Recipient Address

Enter the complete address (street, city, state, and ZIP code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 — Date of Birth

Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 25, 1975, would be 09/25/1975).

Element 6 — Sex

Enter an "X" to specify whether the recipient is male or female.

Element 7 — Billing Provider's Name, Address, ZIP Code

Enter the billing provider's name and complete address (street, city, state, and ZIP code). *No other information should be entered into this element since it also serves as a return mailing label.*

Element 8 — Billing Provider Telephone Number

Enter the billing provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 — Billing Provider No.

Enter the billing provider's eight-digit Medicaid provider number.

Appendix 14 (Continued)

Element 10 — Dx: Primary
Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested for the recipient.

Element 11 — Dx: Secondary
Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

Element 12 — Start Date of SOI (not required)

Element 13 — First Date Rx (not required)

Element 14 — Procedure Code (not required)

Element 15 — MOD
Enter the modifier corresponding to the type of therapy listed below:

Modifier	Therapy Type
OT	Occupational Therapy
PT	Physical Therapy
Leave blank — no modifier required	Speech and Language Pathology

Element 16 — POS
Enter the number of the place of service in which therapy will *usually* be provided:

Code	Description
0	Other
3	Clinic
4	Home

Element 17 — TOS
Enter the appropriate Medicaid single-digit type of service code:

Code	Description
1	All other provider types
9	Rehabilitation agency

Element 18 — Description of Service
Enter "Birth to 3" and the type of therapy services (e.g., "Birth to 3 OT services" for occupational therapy services).

Element 19 — QR (not required)

Element 20 — Charges (not required)

Element 21 — Total Charge (not required)

Element 22 — Billing Claim Payment Clarification Statement
An approved authorization does not guarantee payment. Reimbursement is contingent upon the recipient's and provider's eligibility at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is in accordance with Wisconsin Medicaid

methodology and policy. If the recipient is enrolled in a managed care program at the time a prior authorized service is provided, Wisconsin Medicaid reimbursement is only allowed if the service is not covered by the managed care program.

Element 23 — Date

Enter the month, day, and year (in MM/DD/YYYY format) the Prior Authorization Request Form (PA/RF) was completed and signed.

Element 24 — Requesting Provider Signature

The signature and credentials of the provider performing the service must appear in this element. In the blank space to the right of Element 24, indicate the start date for which services are being requested.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER — THIS SPACE IS USED BY WISCONSIN MEDICAID CONSULTANTS AND ANALYSTS.

Appendix 15

Sample Prior Authorization Request Form (PA/RF) to Be Submitted with the Prior Authorization/Birth to 3 Therapy Attachment (PA/B3)

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. #

1 PROCESSING TYPE: 162

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima
4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow St. Anytown, WI 55555
5 DATE OF BIRTH: MM/DD/YYYY
6 SEX: M ☐ F ☒
8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I.M. Billing, 1 W. Williams, Anytown, WI 55555
9 BILLING PROVIDER NO.: 87654300
10 DX: PRIMARY: 783.4 Developmental delays
11 DX: SECONDARY:
12 START DATE OF SOI:
13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
		4	1	Birth to 3 SLP services		
					TOTAL CHARGE	21

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YYYY (DATE)
24 I.M. Provider (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:
☐ APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED
☐ MODIFIED — REASON:
☐ DENIED — REASON:
☐ RETURN — REASON:

DO NOT write in this space.
Reserved for Medicaid use.

DATE
CONSULTANT/ANALYST SIGNATURE

482-120

Appendix 16

Prior Authorization/Birth to 3 Therapy Attachment (PA/B3) (for photocopying)

(A copy of the Prior Authorization/Birth to 3 Therapy Attachment [PA/B3] is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11011 (06/02)

STATE OF WISCONSIN

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / BIRTH TO 3 THERAPY ATTACHMENT (PA/B3)

The Wisconsin Medicaid program requires information to enable the Medicaid program to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information shall include but is not limited to information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to the Medicaid program administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

REMINDER TO PROVIDERS
Providers are reminded that all services must meet the rules and regulations of Wisconsin Medicaid as found in HFS 101-108, Wis. Admin. Code. Providers are further reminded that prior authorization (PA) does not guarantee payment for the service.

SUBMITTING PRIOR AUTHORIZATION REQUESTS
Attach this form to the Prior Authorization Request Form (PA/RF). Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers may also mail requests to Wisconsin Medicaid at:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Name — Recipient (Last, First, Middle Initial)	Recipient Medicaid Identification Number
Name — Therapist (Last, First, Middle Initial)	Therapist or Rehabilitation Agency Medicaid Provider Number

By my signature below, I hereby attest that:

- I am providing an evaluation completed for the purpose of determining the recipient's eligibility for the Birth to 3 Program or for the purpose of initiating and/or providing therapy services as part of the Individualized Family Service Plan (IFSP) developed for the recipient.

OR

- I am providing ongoing therapy services and I certify that all of the following are true:
  - √ The IFSP for the child named above was or will be developed and implemented in accordance with the requirements set forth in HFS 90, Wis. Admin. Code.
  - √ The therapy services I am providing to the recipient named above are as stated in the child's current and valid IFSP.
  - √ The frequency and duration of services I am providing to the child named above reflects the frequency and duration of services listed in the recipient's IFSP.
  - √ The recipient of the services is enrolled in a Birth to 3 (B-3) Program for all dates of service and is younger than three years of age.
  - √ I am a therapist employed by a B-3 Program or am under agreement with a B-3 agency to provide B-3 services.
  - √ The therapy services provided meet all the applicable rules and regulations as stated in HFS 101-108, Wis. Admin. Code, and *Wisconsin Medicaid and BadgerCare Updates*.
  - √ I understand that I am required to maintain a record of services provided to the child named above, per HFS 106, Wis. Admin. Code.

SIGNATURE — Therapist	Date Signed (MM/DD/YYYY)

Reset Form

Allowable Types of Service and Places of Service for Specific Providers		
	Type of Service	Place of Service*
Independent Therapists, Therapy Groups, and Therapy Clinics	1	0, 1, 2, 3, 4, 7, 8
Rehabilitation Agencies	9	0, 3, 4, 7, 8

Procedure Code	Description	Daily Service Limit**	Billing Limitations	Additional Conditions
31575	Laryngoscopy, flexible fiberoptic; diagnostic	1		Use this code if speech-language pathologist actually inserts laryngoscope. Do not use this code if speech-language pathologist is providing an analysis and does not insert the laryngoscope; instead, use code 92506 or 92610, as appropriate. For treatment, use 92507 or 92526, as appropriate. This service is to be performed according to the American Speech-Language-Hearing Association (ASHA) Code of Ethics and ASHA Training Guidelines for Laryngeal Videoendoscopy/Stroboscopy.
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy	1		Use this code if speech-language pathologist actually inserts laryngoscope. Do not use this code if speech-language pathologist is providing an analysis and does not insert the laryngoscope; instead, use code 92506 or 92610 as appropriate. This service is to be performed according to the ASHA Code of Ethics and ASHA Training Guidelines for Laryngeal Videoendoscopy/Stroboscopy.

*Place of service
0 = Other 4 = Home
1 = Inpatient Hospital 7 = Nursing Home/Extended Care
2 = Outpatient Hospital 8 = Skilled Nursing Facility
3 = Doctor Office
**In accordance with Medicare, providers cannot bill for services performed for less than eight minutes.

Appendix

Appendix 17 (Continued)

Procedure Code	Description	Daily Service Limit*	Billing Limitations	Additional Conditions
92506**	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status	1	Cannot use on the same date of service (DOS) as 96105 or 92510.	This code is also used for re-evaluation.
92507**	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual	1	Cannot use on the same DOS as 92510.	Therapy addressing communication/cognitive impairment should use this code. If treatment focus is aural rehabilitation as a result of cochlear implant, use code 92510.
92508**	group, two or more individuals***	1		Group is limited to two to four individuals.
92510	Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming	1	Cannot use on the same DOS as 92506 or 92507.	Prior authorization is always required. Use this procedure code for evaluation and treatment.
92511	Nasopharyngoscopy with endoscope (separate procedure)	1		Use this code if speech-language pathologist actually inserts endoscope. Do not use this code if speech-language pathologist is providing an analysis and does not insert the scope; instead, use code 92506 or G0195 as appropriate. Use this code for evaluation of dysphagia or assessment of velopharyngeal insufficiency or incompetence. This service is to be performed according to the ASHA Code of Ethics and ASHA Training Guidelines for Laryngeal Videoendoscopy/Stroboscopy.
92512	Nasal function studies (eg, rhinomanometry)	1		Use this code if completing aerodynamic studies, oral pressure/nasal airflow, flow/flow studies, or pressure/pressure studies.
92520	Laryngeal function studies	1		Use this code for laryngeal air flow studies, subglottic air pressure studies, acoustic analysis, EGG (electroglottography) laryngeal resistance.

*In accordance with Medicare, providers cannot bill for services performed for less than eight minutes.
**Procedure code may be billed under the Birth to 3 (B-3) prior authorization (PA) process.
***Wisconsin Medicaid limits group to two to four individuals.

Procedure Code	Description	Daily Service Limit*	Billing Limitations	Additional Conditions
92526**	Treatment of swallowing dysfunction and/or oral function for feeding	1		The recipient must have an identified physiological swallowing and/or feeding problem. This is to be documented using professional standards of practice such as identifying oral phase, esophageal phase or pharyngeal phase dysphagia, baseline of current swallowing and feeding skills not limited to signs of aspiration, an oral mechanism exam, report of how nutrition is met, current diet restrictions, compensation strategies used, and level of assistance needed.
92599	Unlisted otorhinolaryngological service or procedure	1		Prior authorization is always required. Use this code when no other *Current Procedural Terminology* code description appropriately describes the evaluation or treatment.
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	1.5***	Cannot use on the same DOS as 92506, G0197, G0199, or G0200.	
G0193	Endoscopic study of swallowing function (also fiberoptic endoscopic evaluation of swallowing) (FEES)	1		
G0194	Sensory testing during endoscopic study of swallowing referred to as fiberoptic endoscopic evaluation of swallowing with sensory testing (FEEST)	1	Only allowable when used in conjunction with G0193.	
G0195**	Clinical evaluation of swallowing function (not involving interpretation of dynamic radiological studies or endoscopic study of swallowing)	1		

*In accordance with Medicare, providers cannot bill for services performed for less than eight minutes.
**Procedure code may be billed under the B-3 PA process.
***96105: The procedure code description defines this code as one hour. One unit of this code = 1 hour. A maximum of 90 minutes or 1.5 units is allowable. If less or more than one hour is used, bill in decimals to the nearest quarter hour. For example, 45 minutes = .75 and 30 minutes = .5.

Appendix 17 (Continued)

Procedure Code	Description	Daily Service Limit*	Billing Limitations	Additional Conditions
G0196	Evaluation of swallowing involving swallowing of radio-opaque materials	1		Accompanying a recipient to a swallow study is not reimbursable. This code involves the participation and interpretation of results from the dynamic observation of the patient swallowing materials of various consistencies. It is observed fluoroscopically and typically recorded on video. The evaluation involves using the information to assess the patient's swallowing function and developing a treatment plan for the patient.
G0197**	Evaluation of patient for prescription of speech-generating devices	1	Cannot use on the same DOS as 96105.	This code describes the services to evaluate a patient to specify the speech-generating device recommended to meet the patient's needs and capacity. Evaluation of picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code; instead, use code 92506.
G0198**	Patient adaptation and training for use of speech-generating devices	1		This code describes the face-to-face services delivered to the patient to adapt the device to the patient and train him or her in its use. Therapy with a focus on picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code; instead, use code 92507.
G0199**	Re-evaluation of patient using speech-generating devices	1	Cannot use on the same DOS as 96105.	This code describes the services to re-evaluate a patient who had previously been evaluated for a speech-generating device, and is either currently using a device or did not have a device recommended. Re-evaluation of picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code; instead, use code 92506.

*In accordance with Medicare, providers cannot bill for services performed for less than eight minutes.

**Procedure code may be billed under the B-3 PA process.

Procedure Code	Description	Daily Service Limit*	Billing Limitations	Additional Conditions
G0200**	Evaluation of patient for prescription of voice prosthetic	1	Cannot use on the same DOS as 96105.	This code describes the services to evaluate a patient for the use of a voice prosthetic device, e.g., electrolarynx or tracheostomy speaking valve. Evaluation of picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code; instead, use code 92506.
G0201**	Modification or training in use of voice prosthetic	1		Examples of voice prosthetic devices include, but are not limited to, electrolarynx and tracheostomy-speaking valves. Therapy to address picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code; instead, use code 92507.

*In accordance with Medicare, providers cannot bill for services performed for less than eight minutes.
**Procedure code may be billed under the B-3 PA process.

Appendix 18

How "Medical Necessity" Is Applied When Evaluating Prior Authorization Requests for Therapy Services

Application of Medical Necessity to Prior Authorization Requests

Wisconsin Medicaid relies on its definition of medical necessity to determine whether a particular item, service, or procedure may be paid for with Medicaid funds.

Wisconsin Medicaid uses the prior authorization (PA) process to determine medical necessity and to assure that appropriate therapy services are provided to Medicaid participants. Wisconsin Medicaid uses the standards of medical necessity to assist in defining thresholds for decision making. It is important to remember that Wisconsin Medicaid may only approve a PA request if all the standards of the definition of medical necessity are met.

Health care professionals licensed in physical therapy, occupational therapy, or speech therapy employed by Medicaid apply the definition of medical necessity in HFS 101.03(96m), Wis. Admin. Code, on a case-specific basis. These standards permit incorporation of individualized risks, benefits, and preferences and also allow for reasonable differences in providers' judgments and beliefs about available treatments.

The determination of medical necessity is based on the documentation submitted by the provider. Therefore, it is essential that the information be complete, accurate, and specific to each individual's current condition and needs to justify the service requested.

On a PA request for therapy services, Wisconsin Medicaid consultants look for:

- A comprehensive assessment that identifies potentially remediable impairments and objectively measures functional skills and performance.
- An individualized plan of care that addresses the patient's specific set of problems.
- An identification of the expected outcomes of intervention.
- An expectation of how long it will take to achieve the desired outcomes, including requested frequency and duration of intervention and discharge criteria.

This comprehensive information about the individual helps to establish the functional potential of the recipient and forms the basis for determining whether the recipient will benefit from treatment. Medicaid consultants rely on this written documentation as a critical part of the determination of medical necessity. The information provided in the PA request is reviewed to determine whether or not therapy services provided at a certain point in time will be effective in achieving predictable, demonstrable, and attainable results to each individual in a cost-effective manner. The focus of medically necessary therapy services in Wisconsin Medicaid is on intervention activities designed to produce specific outcomes. These outcomes should have a functional basis.

Each PA request presents an individual-specific situation and circumstance and is reviewed on the facts of the case. No single factor such as diagnosis or age of the recipient will result in immediate approval or automatic denial of a PA request for therapy services.

In 96% of the PA requests adjudicated for therapy services, providers document in sufficient detail to justify the medical necessity of the therapy service.

Common reasons given for Medicaid therapy consultants' findings of lack of medical necessity include:

- Documentation fails to support that intervention by a skilled professional is needed.
- Baseline performance is not documented in terms of current level of function or skills of the individual.
- Clinical information is not provided in sufficient detail to suggest that treatment goals are reasonable given the current age and health status of the individual, or that attainment of the goals would result in predictable functional improvement to the individual.
- Individual has failed to make progress toward the targeted goals and objectives in a reasonable time period and the therapist has not modified the treatment plan or objectives in spite of the anticipated outcomes not being achieved.

It is essential that providers review each PA request before submission to ensure that it includes the critical information necessary to support the request in compliance with Wisconsin Medicaid's definition of medical necessity as it is defined in Wisconsin Administrative Code.

Before submitting a PA request it is important that the following questions are considered and answered in the PA request:

- What specific results are expected from this intervention?
- What factors led to the determination that this intervention is necessary?
- What unique skills of a therapist are required to meet the goals in the plan of care?
- Are there other, more cost-effective means available to meet the individual's needs?

Examples of How "Medically Necessary" is Applied to Prior Authorization Requests

The following information and case examples are offered to illustrate how the standards of "medically necessary," as defined in HFS 101.03(96m), Wis. Admin. Code, are applied by Medicaid therapy consultants when adjudicating PA requests.

HFS 101.03(96m)(a) — Required to prevent, identify or treat a recipient's illness, injury or disability;

Example 1: Many individuals having the same diagnosis may have certain characteristics in common; however, the physical expression and functional severity of their conditions can vary greatly. As a result, documentation in the PA request must include a medical diagnosis as well as a problem statement (treatment diagnosis) related to the medical diagnosis that identifies the specific treatment needs of the individual.

For example, physical therapy is requested for a four-year-old child with spastic diplegic cerebral palsy and a gross motor age equivalency of 44-48 months. A plan of care to address "continued development of age-appropriate mobility skills" would not meet the Medicaid application of this standard because no impairments, functional limitations, or disabilities have been identified. The reviewer would question how the requested service treats an illness, injury, or disability. If the therapist identified tight hamstrings but provided no evidence that hamstring contractures were causing any functional problems, the same questions remain.

If instead, the physical therapist's evaluation identified functional limitations including problems with climbing, frequent falls when walking from the bus to home, or other restrictions in outdoor mobility due to tight hamstrings, it may be appropriate to authorize a limited course of physical therapy (PT). In this case, PT may be necessary to improve dynamic range of motion and lower extremity strength, to facilitate functional skill acquisition, and to educate the recipient/caregivers on a home program including recommendations about when to seek medical attention for developing problems, such as worsening contractures.

Example 2: A nine-year-old is an independent household ambulator and presents with hypotonic trunk muscles. He has been receiving occupational therapy for the past six months. The new PA request includes continued treatment strategies of trunk elongation and rib cage mobilization with ongoing goals of preparing for strengthening/stability exercises and preventing frequent respiratory infections. No documentation of trunk range of motion, upper body strength testing, or frequency of respiratory infection is provided.

Measurable goals reflect treatment that is expected to reduce identified impairments, produce sustained changes in function, and are necessary to describe how treatment will affect injury, illness, or disability. The medical necessity of the plan of care would be questioned because no deficits are reported and no evidence is provided to support that soft tissue mobilization has resulted or would likely result in any sustainable change in the client's trunk control or any improvement in functional performance over time. The PA documentation does not support that a correlation exists between improving rib cage mobility and decreasing the client's susceptibility to respiratory infections. The PA request would be returned requesting this additional information.

HFS 101.03(96m)(b)1 — Meets the following standards: Is consistent with the recipient's symptoms, or with the prevention, diagnosis or treatment of the recipient's illness, injury or disability;

Example 1: The client is a 35-year-old with cerebral palsy who is seven weeks post ankle fusion. Prior to surgery, she had been able to ambulate with a walker in her home. The PA request includes a PT plan of care to assess and/or teach transfer skills and evaluate orthotics and equipment needs. This plan of care reflects a situation where episodic therapy is warranted to maximize functional capacity following an orthopedic intervention. This PA request would be approved because it is consistent with treatment of the client's recent change in medical condition.

Example 2: A 16-year-old with a remote history of anoxic brain injury is dependent for all activities of daily living (ADLs). An occupational therapy (OT) PA request is submitted to increase head control at midline from the recipient's current level of 3-5 seconds to 5-10 seconds. No progress has been documented in this area following extensive intervention to improve head control. When functional limitations persist for long periods and have not been remediable, compensatory strategies may be more appropriate. The PA request would be returned for additional information to support the benefit of continued direct treatment for improving head control as an effective or functional intervention.

HFS 101.03(96m)(b)2 — Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

Example: A PA request for sensory integration therapy is submitted for a nine-year-old with pervasive developmental disorder. Goals include decreased behavioral outbursts in natural environments like a noisy gym or shopping mall, improved sleeping patterns, and better ability to "self regulate." The PA would be returned asking the provider to explain how skills learned in therapy would be generalized from the controlled environment of the clinic setting to the child's natural environment(s) of home, school, or community. The Medicaid consultant may further question whether these issues would be more appropriately addressed by a behavioral therapist or through a consistent behavioral management home program.

HFS 101.03(96m)(b)3 — Is appropriate with regard to generally accepted standards of medical practice;

Example 1: A PA is submitted with the therapist reporting that an individual is "not testable" or with the majority of the therapy evaluation obtained from unstructured observation or from other sources. If the treating therapist is unable to establish an individual's baseline functional skills and limitations, it will be impossible to later evaluate and document any changes that may result from therapeutic intervention. Initiating treatment without performing a comprehensive assessment that includes baseline measurements of the individual's abilities and physical impairments is not appropriate with regard to generally accepted standards of practice. If a problem area is not/cannot be tested during the initial evaluation, it should be explained why data could not be obtained and that subsequent PAs will contain baseline data for reported problem areas as well as interval progress. This PA would be returned asking for additional information.

Example 2: An occupational therapist working with a child with a history of dysphagia submits a PA request with a goal for the child to tolerate a wider variety of foods. No clinical assessment of the child's oral motor/swallowing skills or results from a radiological swallow study have been documented to indicate that the proposed oral intake is safe. The PA request would be returned requesting this additional clinical information to assure that the treatment goals are appropriate.

HFS 101.03(96m)(b)4 — Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;

Example: An 85-year-old is eight weeks post hip fracture with subsequent open reduction and internal fixation. The plan of care submitted with the PA includes goals of transferring with assistive device, achieving independence on stairs, and increasing unilateral weight bearing for improved balance, strength, and endurance while walking. No weight bearing restrictions or hip precautions are included in the information submitted. In the absence of this standard medical information, the reviewer may question whether the goals are appropriate (or possibly contraindicated) depending on the recommended postoperative hip precautions. Also, the requested frequency or intensity of therapy may be inappropriate depending on the recipient's weight bearing status.

HFS 101.03(96m)(b)5 — Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;

In assessing whether a service is experimental in nature, the Department of Health and Family Services shall consider whether the service is a proven effective treatment for the condition for which it is intended or used, as evidenced by:

- The current and historical judgment of the medical community (as reflected by medical research, studies, or publications in peer-reviewed journals).
- The extent to which other health insurers provide coverage for the service.
- The current judgment of experts or specialists in the medical area for which the service is to be used.
- The judgment of the Wisconsin Medicaid Medical Audit Committee of the Wisconsin Medical Society or of any other committee which may be under contract with the department as identified in Wisconsin Administrative Code.

The following interventions have been determined to be experimental: Facilitated Communication and Auditory Integration Therapy. The Wisconsin Medical Society has also determined that electrical stimulation for the treatment of open wounds can only be applied to Stage III or IV decubiti. Prior authorization for continued treatment is considered only if granulation tissue has formed or a 25% reduction in the affected area has occurred within 45 days of initiating electrical stimulation. Any PA request for electrical stimulation that falls outside these parameters is considered unproven and would be denied.

HFS 101.03(96m)(b)6 — Is not duplicative with respect to other services being provided to the recipient;

Example 1: A 78-year-old with a diagnosis of Alzheimer's disease resides in a nursing home that specializes in the care of Alzheimer patients. The client transfers with moderate assistance and receives PT two times per week for gait training and to improve transfer skills. The client's transfer and ambulation skills have not progressed over the past month and the nursing staff has been instructed in safe transfer and ambulation techniques. The PT plan of care recommends continued PT services designed to maintain the client's abilities, stating that the client requires the skills of a therapist because she has Alzheimer's. Caregivers who have been properly instructed by a physical therapist regarding the client's unique set of problems should be skilled in working with this patient. Therefore, this PA request would be denied because it is duplicative to the client's maintenance care program.

Example 2: A child with autism is receiving intensive behavioral services with treatment goals of improved peer play, turn taking, sharing, and concentrating on conversation. The OT PA request includes goals for the child to participate in a group game following rules with proper sequencing and attention to task. In this case, the requested therapy is not coordinated with the goals and activities of all other medical, educational, and vocational disciplines involved with the client. The clinical intent of both services appears to be directed toward achieving the same outcome. Therefore, the PA request would be returned for clarification.

HFS 101.03(96m)(b)7 — Is not solely for the convenience of the recipient, the recipient's family or a provider;

Example 1: A child with a history of traumatic brain injury receives PT services at school during the academic year. The Individualized Education Program does not include recommendations for Extended School Year PT over the summer months. Physical therapy services are being requested at a community-based clinic during the summer because, without therapy, the client's day lacks structured activities. Unless the services being requested require the professional skills of a therapist, the request may be viewed as an alternative to recreational or other community-based activities and appears to be submitted solely for convenience.

Example 2: An OT PA request is submitted to provide range of motion and strengthening. The individual has skills that are sufficient to perform the program at home with supervision or in a community or recreational setting. In this case, the PA would be returned for additional information to explain why the skills of a therapist are required.

HFS 101.03(96m)(b)8 — With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and

Example 1: A physical therapist has requested therapy services three times per week to work on a plan of care that is focused on repetition of skills to build endurance. A PA request for PT services at this frequency would be modified or denied. It would be more cost-effective for the client to work on building endurance through a home exercise program. Modification would allow the therapist to monitor the client's progress and to revise the home program as needed, instead of providing direct therapy to work on repetition of an already achieved skill. Programs that involve ongoing muscle strengthening and fitness often involve instructing the client to carry out activities independent of assistance or stressing recreational activities that encourage mobility and reinforce functional movement.

Example 2: An OT PA request is received to provide range of motion for a client who resides in a nursing home. A restorative nursing plan is in place and meets the functional needs of this individual. The therapy plan of care being requested does not include more advanced functional outcomes requiring the skills of a therapist. Occupational therapy services, in addition to restorative nursing, are not cost-effective and the PA request would be denied.

HFS 101.03(96m)(b)9 — Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient;

Example: A 10-year-old child with cerebral palsy has received many years of OT. His current level of functional upper extremity dressing skills includes the ability to push his arm through his sleeve only when the shirt is held over his head and the sleeve is held in place for him. No volitional grasp or release is demonstrated. The OT plan of care is submitted for ongoing direct treatment to improve independent living skills. For this individual, it appears that he has reached a plateau, that no functional gains in upper extremity dressing skills can reasonably be anticipated, and that compensatory strategies and equipment are the most appropriate level of service that can be effectively provided. The direct skills of an occupational therapist may no longer be necessary at this time to maximize his functional performance. A more appropriate level of service may be provided by an occupational therapist on a consultative basis to monitor compensatory strategies and equipment and to evaluate further direct OT needs.

Appendix 18
(Continued)

Relationship of Medical Necessity Definition to Clinical Practice Principles

In conclusion, therapy services reimbursed by Wisconsin Medicaid reflect the following principles of clinical therapy practice:

- An intervention plan should not be based solely on the presence of a medical diagnosis.
- Frequency or duration of treatment is determined by rate of change as a result of therapy, rather than level of severity.[1]
- Decisions about direct service intervention are contingent on timely monitoring of patient/client response and progress made toward achieving the anticipated goals and expected outcomes.[2]
- The need for the service has been determined by the primary caregivers working together on behalf of the individual.
- Families/caregivers affect the priorities for intervention through their direct and proactive participation in the therapeutic process and should be encouraged to participate in all treatment decisions.
- Intervention is unlikely to promote lasting functional improvements if the only opportunity to develop new skills occurs during sessions with the therapist.
- Therapeutic intervention strategies include an educational focus and home program that enables the family/caregiver and eventually the individual to facilitate and reinforce long-term gains.

[1] American Occupational Therapy Association (AOTA).

[2] Guide to Physical Therapy, 2001 American Physical Therapy Association, p. 46.

Appendix 19

Prior Authorization Fax Procedures

Providers may fax prior authorization (PA) requests to Wisconsin Medicaid at (608) 221-8616. Prior authorization requests sent to any Wisconsin Medicaid fax number other than (608) 221-8616 may result in processing delays.

When faxing a PA request to Wisconsin Medicaid, providers should be aware of the following:

- Faxing a PA request eliminates one to three days of mail time. However, the adjudication time of the PA request has *not* changed. All actions regarding PA requests are made within the time frames outlined in the Prior Authorization section of the All-Provider Handbook.

- Faxed PA requests must be received by 1:00 p.m., otherwise they will be considered as received the following business day. Faxed PA requests received on Saturday, Sunday, or holidays will be processed on the next business day.

- After faxing a PA request, providers should not send the original paperwork, such as the carbon Prior Authorization Request Form (PA/RF), by mail. Mailing the original paperwork after faxing the PA request will create duplicate PA requests in the system and may result in a delay of several days to process the faxed PA request.

- Providers should not photocopy and reuse the same PA/RF for other requests. When submitting a *new* request for PA, it must be submitted on a new PA/RF so that the request is processed under a new PA number. This requirement applies whether the PA request is submitted by fax or by mail.

- When resubmitting a faxed PA request, providers are required to resubmit the faxed copy of the PA request, including attachments, which includes Wisconsin Medicaid's 15-digit internal control number located on the top half of the PA/RF. This will allow the provider to obtain the earliest possible grant date for the PA request (apart from backdating for retroactive eligibility). If any attachments or additional information that was requested is received without the rest of the PA request, the information will be returned to the provider.

- When faxing information to Wisconsin Medicaid, providers should not reduce the size of the PA/RF to fit on the bottom half of the cover page. This makes the PA request difficult to read and leaves no space for consultants to write a response if needed or to sign the request.

- If a photocopy of the original PA request and attachments is faxed, the provider should make sure these copies are clear and legible. If the information is not clear, it will be returned to the provider.

- Refaxing a PA request before the previous PA request has been returned will create duplicate PA requests and may result in delays.

- If the provider does not indicate his or her fax number, Wisconsin Medicaid will mail the decision back to the provider.

- Wisconsin Medicaid will attempt to fax the PA request to a provider three times. If unsuccessful, the PA request will be mailed to the provider.

Glossary of Common Terms

BadgerCare

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients' health care is administered through the same delivery system.

CMS

Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (DHHS), the CMS administers Medicare, Medicaid, related quality assurance programs and other programs. Formerly known as the Health Care Financing Administration (HCFA).

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid program that provides the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services (DHHS) assurances that the program is administered in conformity with federal law and CMS policy.

DHFS

Department of Health and Family Services. The Wisconsin DHFS administers the Medicaid program. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHHS

Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

Emergency services

Those services which are necessary to prevent death or serious impairment of the health of the individual. (For the Medicaid managed care definition of emergency, refer to the Managed Care Guide or the Medicaid managed care contract.)

EVS

Eligibility Verification System. The EVS allows providers to verify recipient eligibility prior to providing services. Providers may access recipient eligibility information through the following methods:

- Wisconsin Medicaid's Automated Voice Response (AVR) system.
- Commercial magnetic stripe card readers.
- Commercial personal computer software or Internet access.
- Wisconsin Medicaid's Provider Services (telephone correspondents).
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).

Experimental services

According to HFS 107.035, Wis. Admin. Code, a service that is experimental in nature is a service, procedure, or treatment proved by a particular provider which the department has determined under HFS 107.035, Wis. Admin. Code, not to be a proven and effective treatment for the condition for which it is intended or used.

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

HCFA

Health Care Financing Administration. *Please see the definition under CMS.*

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Wisconsin Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Wisconsin Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medically necessary

According to HFS 101.03(96m), a Medicaid service that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and

(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;
3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Natural environment

For the Birth to 3 (B-3) Program, natural environment is defined in both 34 CFR Part 303 and HFS 90.03(25), Wis. Admin. Code, as "settings that are natural or normal for the child's age peers who have no disability." Natural environments may include family child care, inclusive child care centers, or other settings where most of the children do not have disabilities. Natural environments do not include medical facilities such as therapy clinics, physician clinics, rehabilitation agencies, outpatient hospitals, or other center-based settings where most of the children have disabilities.

PA

Prior authorization. The written authorization issued by the Department of Health and Family Services (DHFS) to a provider prior to the provision of a service.

POS

Place of service. A single-digit code that identifies where the service was performed.

SOI

Spell of illness. An SOI is a documented condition in which a recipient has a loss of functional ability to perform daily living skills. This loss of functional ability can be caused by a new disease, injury, medical condition, or by increased severity of a pre-existing medical condition. For a condition to be classified as a new SOI, the recipient must display the potential to reachieve the skill level that he or she had previously.

TOS

Type of service. A single-digit code that identifies the general category of a procedure code.

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